

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WESTPRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 20625	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEGGY ESTELLA MACAIONE										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8-10-82	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8-1-1931		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 51 YRS.		7c. DATE PRONOUNCED DEAD 8-10-82		2b. HOUR 5:28AM	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY				9b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY SECURITY	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD			13b. COUNTY N/A			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST NORMAN K. MacLEOD						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET BETZ					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 217.26.4914				17. INFORMANT ADDRESS KATHLEEN MEEKER 2135 CAMBRIDGE ST. 21231			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5602 IMMEDIATE CAUSE (a) Volvulus Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 8/12/82		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MD.	
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC.						ADDRESS DUNDALK, MD. 21222		25a. DATE REC'D. BY REGISTRAR AUG 17 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

11

RECEIVED  
JAN 11 1964





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 20626

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Charles R. Mac Elrevey</b>		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>8 1 19 82</b>		2b. HOUR M <input type="checkbox"/> M <input type="checkbox"/> <b>4:30</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 9, 1945</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>37</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrical Engineer</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Arnold</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>492 Colonial Ridge Lane</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles A. MacElrevey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Harbaugh</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>177-36-6591</b>		17. INFORMANT ADDRESS <b>Betty Hulton 17 Kings Circle Malvern, Pa.</b>

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

8120 IMMEDIATE CAUSE (a) **Multiple injuries**

DOE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) \_\_\_\_\_  
DOE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>045 P.M. 7 29 19 82</b>	21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 29 19 82</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver in auto/van impact</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>	21f. LOCATION STREET <b>Rt. 50</b>	CITY OR TOWN <b>Annapolis</b>	COUNTY <b>A.A.</b>

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE **Thomas D. Smith** TITLE (SPECIFY)  
**Deputy Chief** MEDICAL EXAMINER

DATE SIGNED **8/2/82**

EXAMINER'S NAME (TYPE OR PRINT) **Thomas D. Smith, M.D.** ADDRESS **111 Penn St. Balto., MD.**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Aug. 5, 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gt. Valley Presbyterian</b>	23d. LOCATION CITY OR TOWN <b>Malvern</b>	COUNTY <b>Penna.</b>	STATE <b>Penna.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>		25. DATE REC'D. BY REGISTRAR <b>AUG - 3 1982</b>		26. REGISTRAR'S SIGNATURE <b>Thomas J. Smith</b>	

THE  
CITY OF  
NEW YORK  
OFFICE OF THE  
COMMISSIONER OF  
THE LAND OFFICE  
ALBANY, N. Y.  
JANUARY 10, 1887

TO THE  
COMMISSIONER OF THE  
LAND OFFICE

ALBANY, N. Y.

DEAR SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,  
J. B. [Signature]

Commissioner of the Land Office

Albany, N. Y.

Very truly,  
Yours,  
J. B. [Signature]

Commissioner of the Land Office

Albany, N. Y.

Very truly,  
Yours,  
J. B. [Signature]

Commissioner of the Land Office

Albany, N. Y.

Very truly,  
Yours,  
J. B. [Signature]

Commissioner of the Land Office

Albany, N. Y.

Very truly,  
Yours,  
J. B. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 82 20627							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD DANIEL MACHIN					2a. DATE OF DEATH MONTH DAY YEAR 08-30-82		2b. HOUR 8:10pm		
1. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 5 1917		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BO + CO		12b. KIND OF BUSINESS OR INDUSTRY R. R.	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 719 S. MILTON AVE	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES MACHIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN TYLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705 09 2935		17. INFORMANT ADDRESS STELLA MACHIN 719 S. MILTON AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) ADENOCARCINOM OF THE LUNG WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 8-30-82 to 8-30-82, that (1) (we) lost the deceased alive on 8-30-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)									
22b. SIGNATURE Dr. I. WALKER M.D.				DEGREE		22c. DATE SIGNED 8/30/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. I. WALKER M.D.	
22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231									
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 9-3-1982		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS		23d. LOCATION BALTIMORE MD.		23e. DATE REC'D. BY REGISTRAR SEP 1 1982	
23f. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI				23g. ADDRESS 2525 FLEET ST		23h. REGISTRAR'S SIGNATURE John J. C... ..			

NOTED  
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JAN 21 1964  
U.S. AIR FORCE  
WASHINGTON, D.C.  
OFFICE OF THE  
JOINT CHIEFS OF STAFF  
MEMORANDUM  
TO: THE SECRETARY OF DEFENSE  
FROM: THE JOINT CHIEFS OF STAFF  
SUBJECT: [Illegible]

RECEIVED  
JAN 21 1964



1. [Illegible]  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 0 6 2 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILTON J. MACK				2a. DATE OF DEATH MONTH DAY YEAR 9 31 82			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 11 16		6. AGE (IN YEARS LAST BIRTHDAY) 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Martin-Marietta		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3712 Overlea Ave - 4206		14. FATHER'S NAME FIRST MIDDLE LAST John F. Mack		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kucera			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-05-0941		17. INFORMANT ADDRESS Charles J. Mack, 6513 Fairdel Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) 440 CARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. C. CHER				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/31/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEQUINA L. CHER				22e. ADDRESS GOOD SAMARITAN HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/3/82		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. Balto, City		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME John S. Miller Inc.				25. DATE RECEIVED BY REGISTRAR SEP 1 1982			
ADDRESS 6415 Belair Rd.				REGISTRAR'S SIGNATURE John S. Miller			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 2 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ROSA MACK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Aug 19<sup>th</sup> 82</b>		2b. HOUR <b>9<sup>PM</sup></b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JUNE 30 1910</b>	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE City Hospital</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>—</b>		13c. STREET ADDRESS <b>633 N. Aisquith St.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JAMES CRAWFORD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SUSIE BLADGON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>220-225923</b>		17 INFORMANT ADDRESS <b>SUSAN ROSE IRELAND / 1033 N. CASTLE ST.</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cancer Pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Menigeoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Brain Cancer</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): <b>Pressure wounds.</b>					
19a. DATE OF OPERATION <b>Apr 1974</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/28/81</b> , 19 <b>82</b> , to <b>5/19/82</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>Aug 10/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>P. NIKOORMANESH</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/19/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. NIKOORMANESH</b>		22e. ADDRESS <b>4940 Eastern Ave. Balt. Md 21224</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>Aug 25, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>		24 FUNERAL DIRECTOR NAME <b>Marshall W. Jones Jr. / 4101 Edmondson Ave / BALTO. MD</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 23 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>J. C. Jones</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

SEP 28<sup>th</sup> 1944

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 3 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CARROLL - MacKALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 29 82</b>			2b. HOUR <b>9:25 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 22 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11 W. 20th St. Apt. 9I</b>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219-16-1356</b>		17. INFORMANT ADDRESS <b>Tryphena Mackall 11 W. 20th St. Apt. 9I</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2507 Rep. Cardio-respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes - Shunt HCVD and ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION <b>07/27/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Chronic LEG ULCER</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>07/26 19 82</b> to <b>08-29 19 82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>08-29-19 82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>L. Hincache MD.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>08/29/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAIME MERCADO</b>				22e. ADDRESS <b>NORTH CHARLES HOSPITAL-BALTO</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/3/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 31 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			



100% COTTON FIBER

MADE IN AUSTRIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 48 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 6 3 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT V. MADDEN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>8-07-82</b>			2b. HOUR <b>7.50 P.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 19 11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Reisterstown</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSP</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1736 NORTH AVE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry A. Madden</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ardela Jones</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-01-4672</b>		17. INFORMANT ADDRESS <b>Mrs. Leone V. Madden Balto, Md. 21217</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm.</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/8/82</b> 19____, to <b>8/9/82</b> 19____, that (I) (we) last saw the deceased alive on <b>8/7/82</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>B. Nagpal</b>						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/7/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. B. NAGPAL</b>						22e. ADDRESS <b>G. S. H. Balto. MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Aug. 19, 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Reisterstown, Md. 21136</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Eline Funeral Home Reisterstown, Md. 21136</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1982</b>					
						25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>					

COMMON

1988-08-27



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IMPORTANT: If item 21 is marked on item 1B there was any injury, or other traumatic event, the medical examiner must be notified of this.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 3 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MITTIE HALL MAGRUDER			2a. DATE OF DEATH MONTH DAY YEAR 8-8-82			2b. HOUR 10 <sup>15</sup> A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KESWICK NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4100 N. Charles Street	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Hall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Bowling							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220 68 3533		17. INFORMANT Florence Magruder,				ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> , 19 <u>82</u> , to <u>8/8</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/8</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>E. Hunter Wilson, Jr.</u>					DEGREE MD			22c. DATE SIGNED 8-8-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Hunter Wilson, Jr., MD					22e. ADDRESS Keswick Home, Balto., Md. 21211					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/10/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg MD		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212					25a. DATE REC'D. BY REGISTRAR (SEE REGISTRAR'S SIGNATURE) AUG 9 1982 <u>John J. Smith</u>					



THE STATE OF NEW YORK  
IN SENATE  
January 1, 1911  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1909  
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1911

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1911

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1911

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 0 6 3 3			
1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Baby girl</i> <b>CYNTHIA MARIE MAHON</b> (LAST) <b>MAHON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8/23/82</b>		2b. HOUR <b>1 P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 21 82</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>2</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>city</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>---</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>md.</b> COUNTY <b>A.A.</b>		13b. CITY OR TOWN <b>Glen Burnie</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>923 Long Cove Rd., Glen Burnie,</b>	
14. FATHER'S NAME FIRST <b>Michael</b> MIDDLE <b>M.</b> LAST <b>Mahon</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Joursula</b> LAST <b>Dumscha</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Michael Mahon, 923 Long Cove Rd., Glen Burnie</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: <b>7599 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congenital Developmental Anomaly</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/21/82</b> 19 to <b>8/23/82</b> 19, that (I) (we) last saw the deceased alive on <b>8/23/82</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>asohillon</b> M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/23/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AMARPREET SINGH DHILLON.</b>		22e. ADDRESS <b>St. Agnes Hospital.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 24, '82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A.A.Co., Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>George J. Gonce, 4001 Ritchie Hg., Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Samuel G. Gonce</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 2 0 6 3 4									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ADDIE		B				maisel		8-28-82		626 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		MONTH DAY YEAR 04-08-99		83		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		ST. AGNES HOSPITAL						Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		Baltimore		Catonsville				500 INGLESDALE AVE.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Robert White				Emma Banks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
NO		213-48-1778		Mrs. Nancy E. Bloomer-Glenelg, MD. 21737							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 0119 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tuberculosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Arteriosclerotic Cardiovascular Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from 7/28/82 to 8/28/82, that (we) last saw the deceased alive on 8/28/82, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
B. K. SINHA						8/28/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
B. K. SINHA		SAINT AGNES HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Sept. 1, 82		Woodlawn Cemetery		Woodlawn Balto. MD.					
24. FUNERAL DIRECTOR NAME & Russell C. Witzke Funeral Home P.A. 1630 Edmondson Ave., Catonsville, MD. 21228						25a. DATE REG'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						AUG 30 1982		John J. Lohr			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial/transit permit. The permit must be removed from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 6 3 5							
1. FOR STATE REGISTRAR		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST JOYCE		MIDDLE E.		LAST MAJORS		2a. DATE OF DEATH		MONTH 08		DAY 14		YEAR 82		2b. HOUR M	
3. SEX FEMALE		4. RACE N		5. DATE OF BIRTH		MONTH 02		DAY 24		YEAR 38		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.											
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 704 Myra Street 21202									
14. FATHER'S NAME FIRST MIDDLE LAST FLOYD - ROBINSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MCKLOUD													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-36-1559		17. INFORMANT ADDRESS Roy Davis 704 Myra Street													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest - asystole</u> 4278 DUE TO, OR AS A CONSEQUENCE OF (b) <u>intracranial hemorrhage / fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/6</u> , 19 <u>82</u> , to <u>8/19</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>David L. Gini</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>8/19/82</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID L. GINI				22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-19-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md							
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave				25a. DATE REC'D BY REGISTRAR AUG 19 1982				25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>									



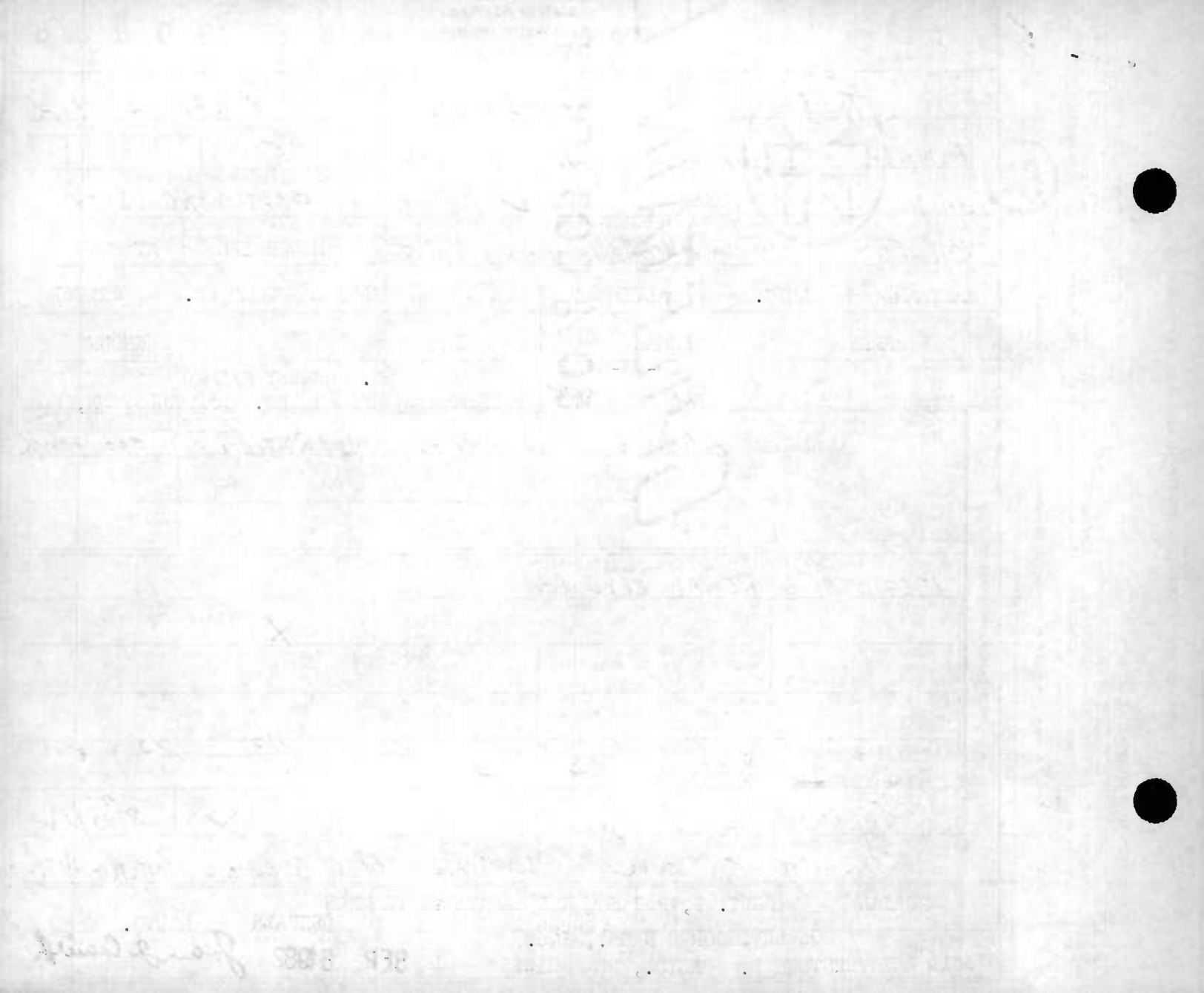
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the county after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item III shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 6 3 6	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Tillie		MIDDLE		LAST MALMUD		2a. DATE OF DEATH MONTH DAY YEAR 8 31 82		2b. HOUR 9 AM	
3 SEX Female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 22 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW GERIATRIC CENTER + HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS 3506 LANGREHR RD.		#21207	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY TOBESMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. <del>1820-03-6495</del> 216-05-7445				17 INFORMANT MR. HERBERT MALMUD ADDRESS 8815 MEADOW HEIGHTS RD. RANDALLSTOWN, MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										21133 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE HOUR	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: METASTATIC RENAL CELL CA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from 8/18, 19 82, to 8/31, 19 82, that (we) last saw the deceased alive on 8/31, 19 82, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death.											
22b. SIGNATURE Cecilia O. Kn				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/31/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELVITA O. KN				22e. ADDRESS LEVINDALE HEBREW GERIATRIC CENTER - HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 1, 1982		23c. NAME OF CEMETERY OR CREMATORY SHOMREI HADATH VE TZEMECH SEDEK		23d. LOCATION COUNTY STATE ROSEDALE BALTO. MD					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR SEP 8 1982		25b. REGISTRAR'S SIGNATURE John J. Carver					



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Rufus</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 31, 1982</b>			2b. HOUR <b>8:52p</b>		
3. SEX <b>male</b>			4. RACE <b>Black</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>2 20 34</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Marable</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mattie Nunnally</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>230-42-6872</b>			17. INFORMANT ADDRESS <b>Rentte Marable 1828 E. North Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure - Arrhythmia</b> <b>4293</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive Cardiomegaly</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 yrs</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>HBP</b>								
19a. DATE OF OPERATION <b>-</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>March 17, 1982</b> to <b>July 7, 1982</b> , that (I) (we) last saw the deceased alive on <b>July 7, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
21g. SIGNATURE <b>Louis N. Randall</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/3/82</b>
21h. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Louis N. Randall, M.D.</b>						22e. ADDRESS <b>2300 Garrison Blvd. Balto., Md. 566-6264</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>9/4/82</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Mitchell Cem</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fort Mitchell Va.</b>			24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North avenue</b>					
25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1982</b>						25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		

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Notes

MINOR

August 21, 1922

1922

Wounded General Hospital

Baltimore

Baltimore City

Wounded General Hospital  
Baltimore

H. 21

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2300 Garrison Bldg. Baltimore, Md. 20004

John H. Randall, M.D.

20% CO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 3 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Annie O. Marine</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 5, 1982</b>			2b. HOUR M			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 24 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4415 Old York Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4415 Old York Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Roland Brunson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Moriah Chavis</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Freddie Marine 2074 Echodale Avenue</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> <b>1790</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MMT Tumor of uterus</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1982</b> , to <b>July 1982</b> , that (I) (we) last saw the deceased alive on <b>July 1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jacob Rotmensca, MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>8/10/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JACOB ROTMENSCA, MD</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/10/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1982</b>		REGISTRAR'S SIGNATURE <b>John J. Canine</b>	

11 MONTHS 2024

2024 11 MONTHS 2024

2024 11 MONTHS 2024

2024 11 MONTHS 2024

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 3 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUTH O MARKEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 7 82</b>		2b. HOUR <b>9:40AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 26 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ALABAMA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT AGNES HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>ARUNDEL</b> 13c. CITY OR TOWN <b>SEVERN</b>			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12c. KIND OF BUSINESS OR INDUSTRY
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles McGraw</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>291-12-1026</b>		17. INFORMANT <b>Robert J. Markey</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4275 IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY Arrest.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		

DUE TO, OR AS A CONSEQUENCE OF (b)				DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8-3</b> , 19 <b>82</b> , to <b>8-7</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8-7</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Andrew Trofa</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/7/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREW TROFA</b>		22e. ADDRESS <b>900 Caton Ave. Baltimore MD 21229</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-11-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Akron Summit Ohio</b>	
24. FUNERAL DIRECTOR NAME <b>Marzullo Funeral Service</b>				ADDRESS <b>Reisterstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>1 AUG 10 1982</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 0 6 4 0			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME				2a. DATE OF DEATH			
(TYPE OR PRINT)				MONTH DAY YEAR			
Baby Giel Marshall Twin B				8/24/82			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		MONTH DAY YEAR		IF UNDER 1 YEAR	
				8 22 82		2 Days YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Balt md		U.S.A.				Baltimore city MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		University of md Hospital					
13a. STATE				13b. STREET ADDRESS			
md				56 Granite Avenue			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
John H. Blackburn				Lois L Marshall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.			
no				NONE			
17. INFORMANT				ADDRESS			
Janice W. Koch							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
7651 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) <u>prematurity</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>pneumothorax</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Susan E. Mumper, MD						8/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Susan E. Mumper				University Hospital, Pediatrics			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		8-27-82		West Nottingham		Coloma Cecil, Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR			
Richard L. Goodie Rising Sun, Md.				AUG 30 1982			

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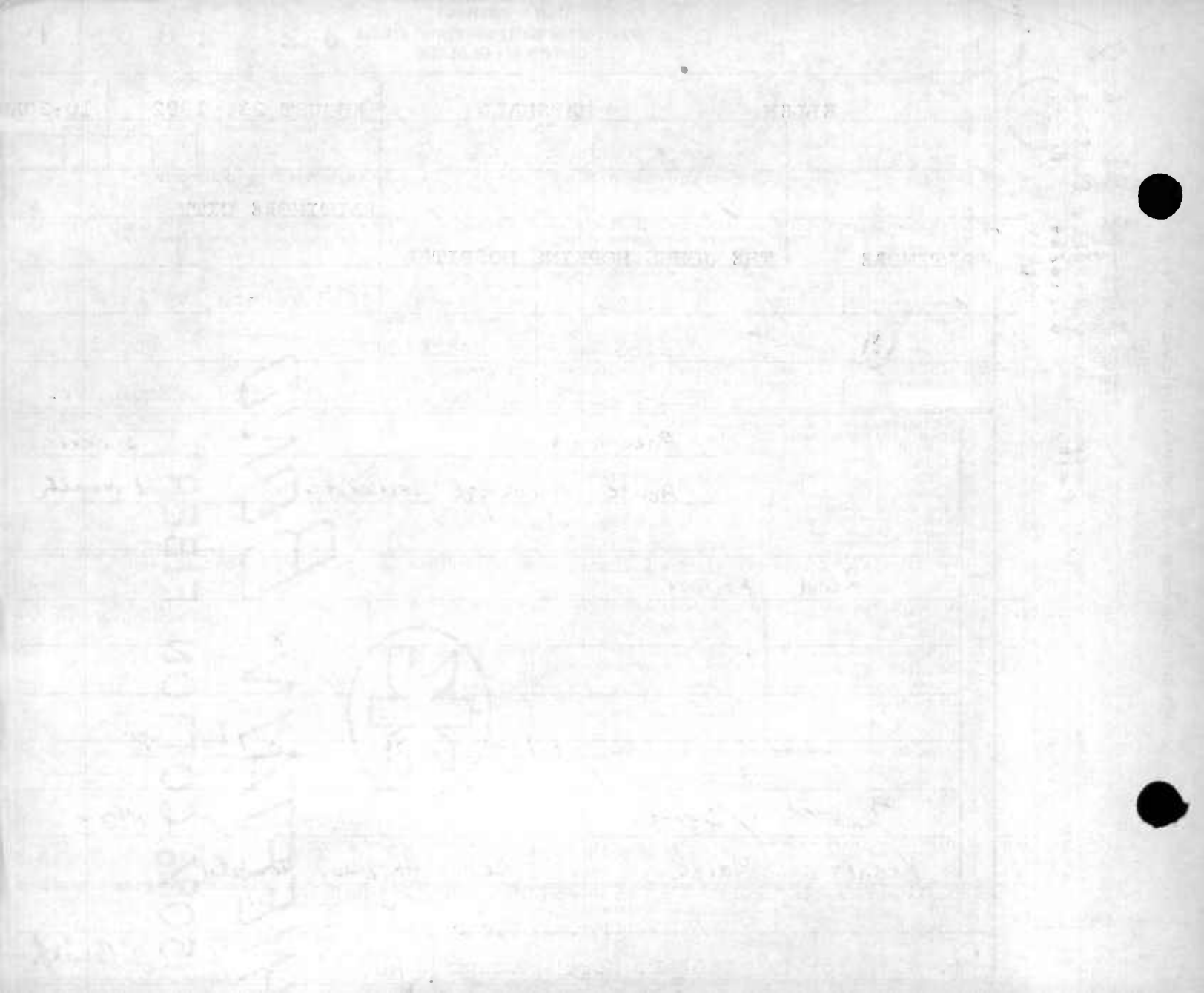


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove the signature pages, and with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposal. IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 6 4 1					
1. FOR STATE REGISTRAR		REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
ELLEN R MARSHALL						AUGUST 23, 1982								10:30AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		Black		MONTH 5 DAY 18 YEAR 24		58 YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA				BALTIMORE CITY MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		THE JOHNS HOPKINS HOSPITAL													
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland								Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3607 Wabash Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Nicholas E. Rice						Beatrice Dennis									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
						212-20-3129		Howard H. Marshall 3607 Wabash Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 2050 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myelocytic Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 month</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Renal Failure</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> , 19 <u>82</u> , to <u>8/23</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/23</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Kenneth Marek</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>8/23</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kenneth Marek</u>						22e. ADDRESS <u>Johns Hopkins Hospital</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				23b. DATE <u>8/27/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Md. Veteran Cem</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Crownville Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H 1101 E. North Avenue</u>						25a. DATE REC'D. BY REGISTRAR <u>AUG 24 1982</u>				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>					

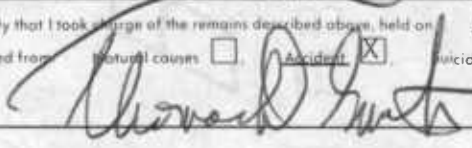



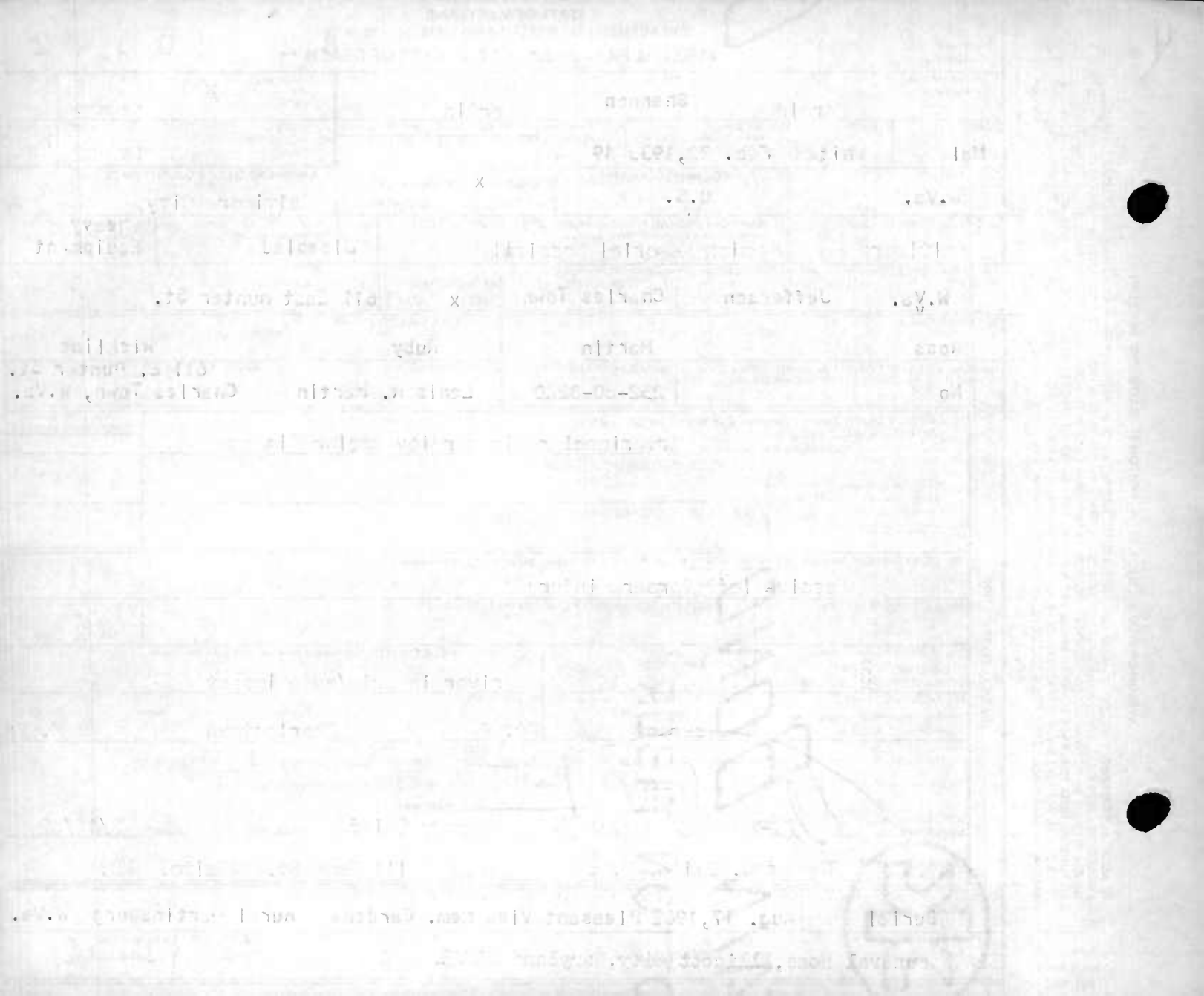


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 82 20642	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Harold Shannon Martin</b>										2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> <input type="checkbox"/> MONTH DAY YEAR <b>8 14 1982</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 20, 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 14 1982</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W.Va.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disabled</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Equipment</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>W.Va.</b>		13b. COUNTY <b>Jefferson</b>		13c. CITY OR TOWN <b>Charles Town</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>611 East Hunter St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ross Martin</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruby Wickline</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>232-60-8220</b>		17. INFORMANT <b>Lenis R. Martin</b>				ADDRESS <b>611 E. Hunter St. Charles Town, W.Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8120</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Massive left forearm injury</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>8:15 P.M.</b> MONTH DAY YEAR <b>8 13 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Driver in auto/auto impact</b>					
21d. INJURY OCCURRED: WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (at home, street, factory, farm, etc.) <b>street</b>		21f. LOCATION STREET <b>Rt. 9</b> CITY OR TOWN <b>Charlestown</b> COUNTY <b>W. Va.</b> STATE <b>W. Va.</b>					
22a. I certify that I took charge of the remains described above, held on _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from _____ Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>M.D. Deputy Chief</b>				DATE SIGNED <b>8/14/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Aug. 17, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant View Mem. Gardens</b>				23d. LOCATION CITY OR TOWN <b>Rural Martinsburg</b> COUNTY <b>W. Va.</b> STATE <b>W. Va.</b>	
24. FUNERAL DIRECTOR NAME <b>SLACK Funeral Home, Ellicott City, Maryland 21043</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>AUG 19 1982</b>		25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed and completely filled in by the funeral director, it should be detached for use as the basic form for the preparation of the death record card. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked for them to show any injury or other traumatic cause, the funeral director must be notified.

FOR - STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 2 0 6 4 3	
1 - DECEASED NAME (TYPE OR PRINT)				CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
Ralph Martino				08/22/82		6:28P	
2. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		White		June 17 1904		78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Italy		U.S.A.				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		John Hopkins Hospital		Self-Employed		Liquor Store	
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Maryland		Cecil Perryville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		327 Aiken Avenue	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Luigi Martino		Rosario Martini		No		215-32-0040	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		19. DATE OF OPERATION		20a. AUTOPSY?	
Nannie M. Martino		5713 IMMEDIATE CAUSE (a). Hepatorenal syndrome		8/16/82		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		DUE TO, OR AS A CONSEQUENCE OF (b). Hepatic disease				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		DUE TO, OR AS A CONSEQUENCE OF (c). Alcoholism				YES <input type="checkbox"/> NO <input type="checkbox"/>	
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
		Adult Respiratory Distress Syndrome, Throat cancer.					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. SIGNATURE	
		P.M. 19				Arthur N. Wang MD	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22b. DATE SIGNED	
						8/22/82	
22a. I certify that (1) (this hospital) attended the deceased from 8/16 to 8/22, 1982, that (1) (we) last saw the deceased alive on 8/22, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		22e. DATE RECEIVED BY REGISTRAR	
		ARTHUR WANG		JOHN HOPKINS HOSPITAL - SURGERY		AUG 31 1982 John J. Cawick	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Aug. 26, 1982		Mt. Erin Cemetery		Havre de Grace Harford Md.	
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
LEE A. PATTERSON & SON		AUG 31 1982		John J. Cawick			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		Item 18b Film 571		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 2 0 6 4 4	
29-23-82 cn		CERTIFICATE OF DEATH		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>SAMANTHA C. MARX</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8 30 82</b>		2b. HOUR <b>12:5 A</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 10 82</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>21</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL BALTO MD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NO</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO CITY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK J. MARX JR.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SUSAN J. LOETELL</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT ADDRESS <b>LINDA HENN NNP SINAI HOSPITAL BALTO MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIC ARREST</b> <b>7775</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>NEC Necrotizing Enterocolitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 days</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>25WK GESTATION</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.							
22b. SIGNATURE <b>Richard Rittnerman M.D.</b>				DEGREE <b>Resident</b>		22c. DATE SIGNED <b>8/30/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Rittnerman</b>				22e. ADDRESS <b>Sinai Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8-31-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Vertha Miller - 7527 Harbor Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 7 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	



ENVIRONMENTAL

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 2 2 0 6 4 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Giuseppa (Josephine) Marziale</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8/23/82</b>		2b. HOUR M P <b>1:00 P</b>	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 9 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Belair Convalesarium</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3551 Elmora Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dario Laverghetta</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Michelina D'Adamo</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>			
16b. SOCIAL SECURITY NO. <b>213-03-4566</b>		17. INFORMANT ADDRESS <b>Valentine Marziale, 3551 Elmora Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>DIABETES MELLITUS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from _____, 19____, to _____, 19____, that (1) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Luis E. Rivera</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <b>8/23/82</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Luis E. Rivera</b>		22d. ADDRESS <b>50 Scott Adam Road Cockeysville, Md. 21030</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/26/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Zannino Funeral Home, 263 S. Conkling</b>		ADDRESS <b>St</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1982</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

«Ваше предложение не имеет смысла»

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34

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 4 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MYRON. K. MATHEWS</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>82</b>			2b. HOUR <b>9:29 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>June</b> DAY <b>26</b> YEAR <b>1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN "C" FACILITY, GIVE STREET ADDRESS) <b>Bon Secour Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Textile Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Mill</b>		
13a. STATE <b>Md</b>			13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Israel</b> MIDDLE <b>Mathews</b> LAST <b></b>				15. MOTHER'S MAIDEN NAME FIRST <b>Eltie</b> MIDDLE <b>C.</b> LAST <b>Lawson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>213 03 4364</b>		17. INFORMANT <b>Myron K. Mathews Jr.</b>			ADDRESS <b>2200 Christian St. 21223</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>3485</b> IMMEDIATE CAUSE (a) <b>Hypoxaemic Nephrosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary edema</b> <b>hrs.</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>cerebral edema</b> <b>hrs.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>DR B. GURESH</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8-8-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR B. GURESH</b>				22e. ADDRESS <b>Bon Secours Hospital Balto Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Vet. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville Md Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Burgee Funeral Home</b>				ADDRESS <b>3631 Falls Road 21211</b>		25. DATE REC'D. BY REGISTRAR <b>AUG 11 1982</b>			

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI (100-371141)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]  
RE: [Illegible]

[Large block of illegible text, likely a body paragraph or list of items]

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DMMH 16-50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

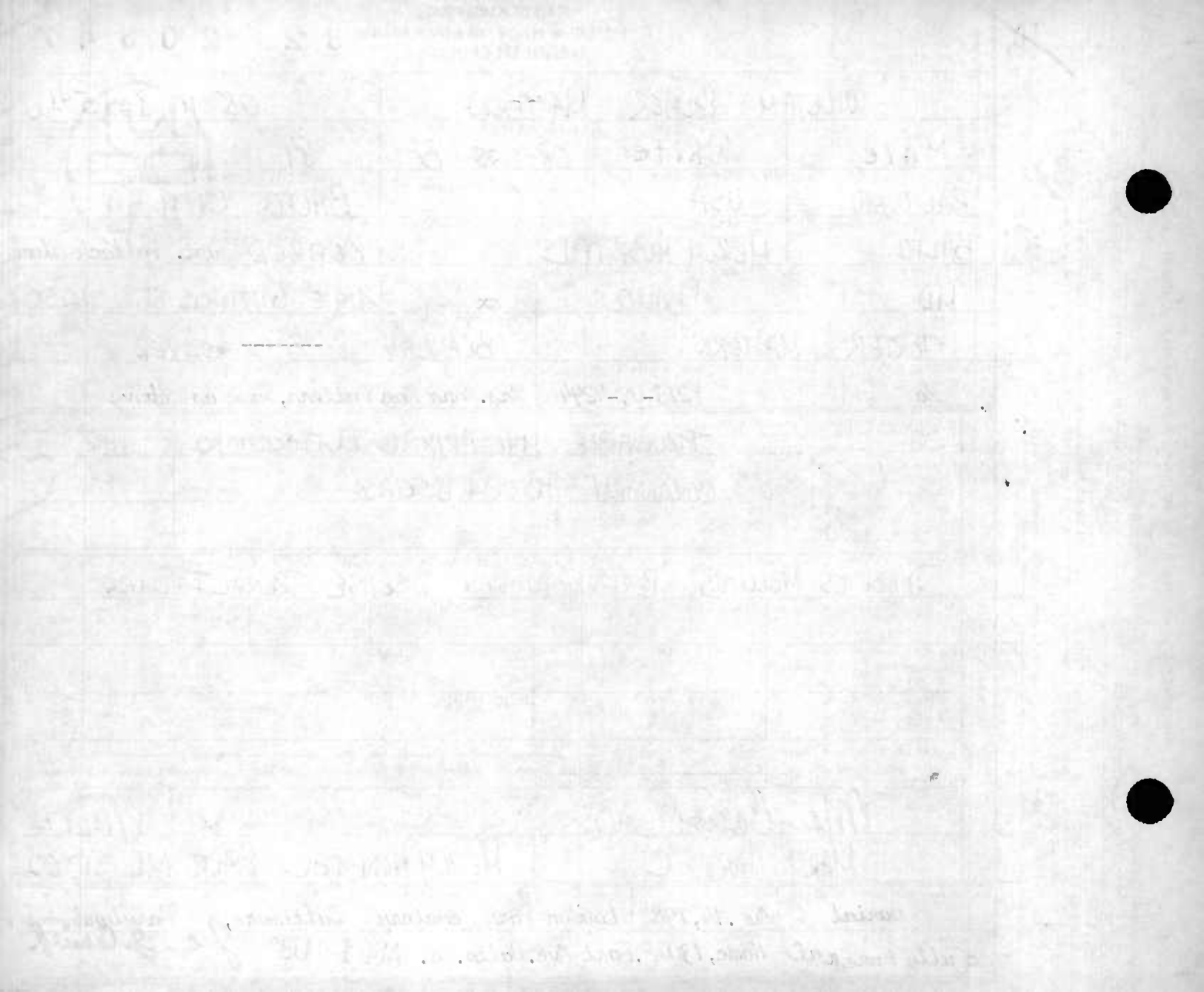
8 2 2 0 6 4 7

REG. NO.

FOR 1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH		2b HOUR	
		WILLIAM PALMER MATTERN		08 11 82		541a	
1 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Male		White		08 25 00		81	
7a BIRTHPLACE (STATE OR FOREIGN)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
BALTO. MD.		USA				BALTO. CITY MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
BALTO.		MERCY HOSPITAL		RETIRED Supt.		Pollack-Blum	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	
PORTER MATTERN		BLANCHE HOOPER		No		215-09-4294	
				17 INFORMANT		ADDRESS	
				Mrs. Anna Mae Mattern, Same as above			
				18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 PROBABLE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1HR.	
				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) DIABETES MELLITUS, PERIPHERAL VASC. DISEASE, RENAL FAILURE			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE Mary Carroll MD.		22c. DATE SIGNED 8/11/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY CARROLL		22e. ADDRESS MERCY HOSPITAL, BALTO. MD. 21202					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)	
Burial		Aug. 14, 1982		Loudon Park Cemetery		Baltimore, Maryland	
24. FUNERAL DIRECTOR McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.		25a. DATE RECD. BY REGISTRAR AUG 18 1982		25b. SIGNATURE John J. Carver			

2712 BP





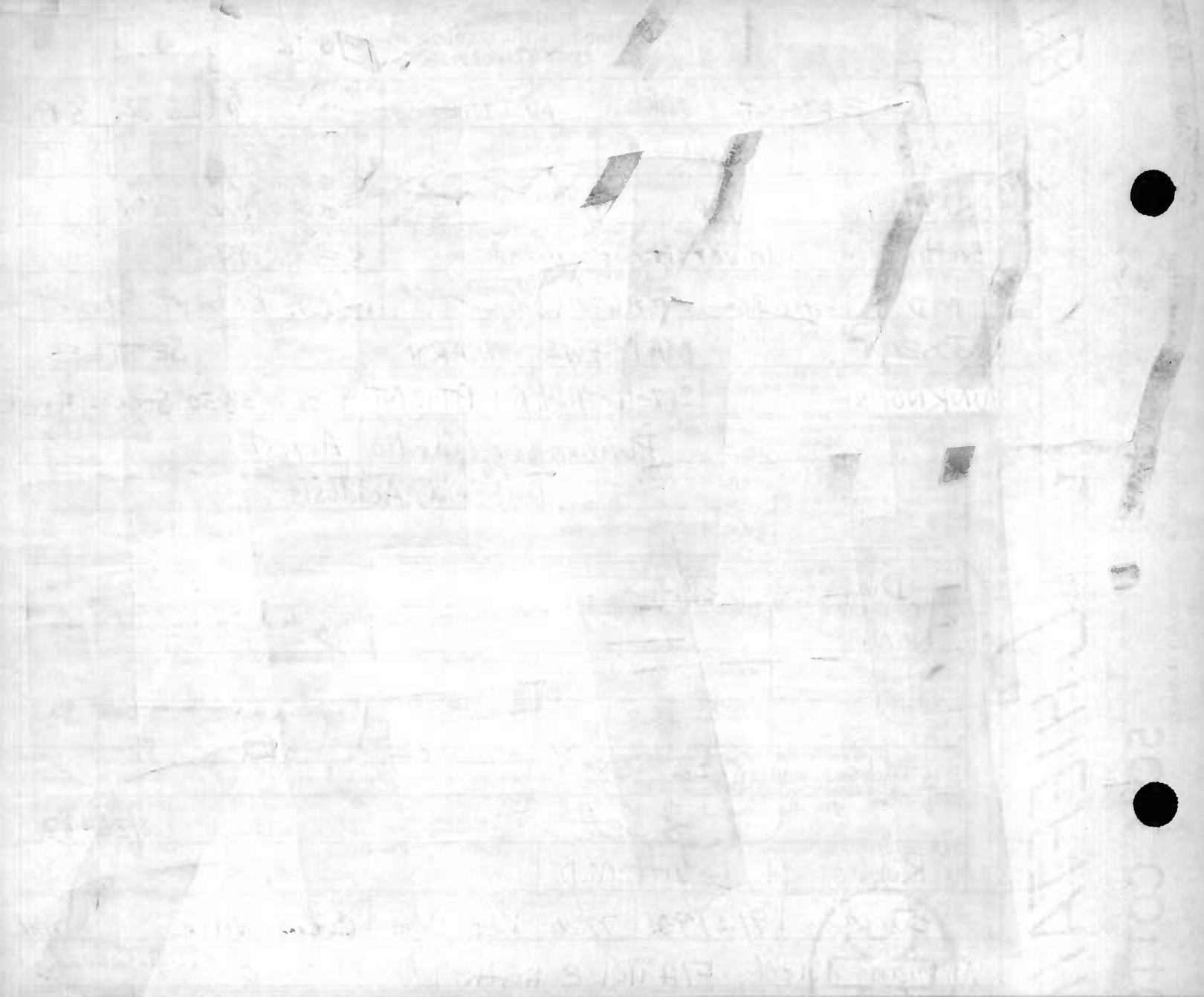
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

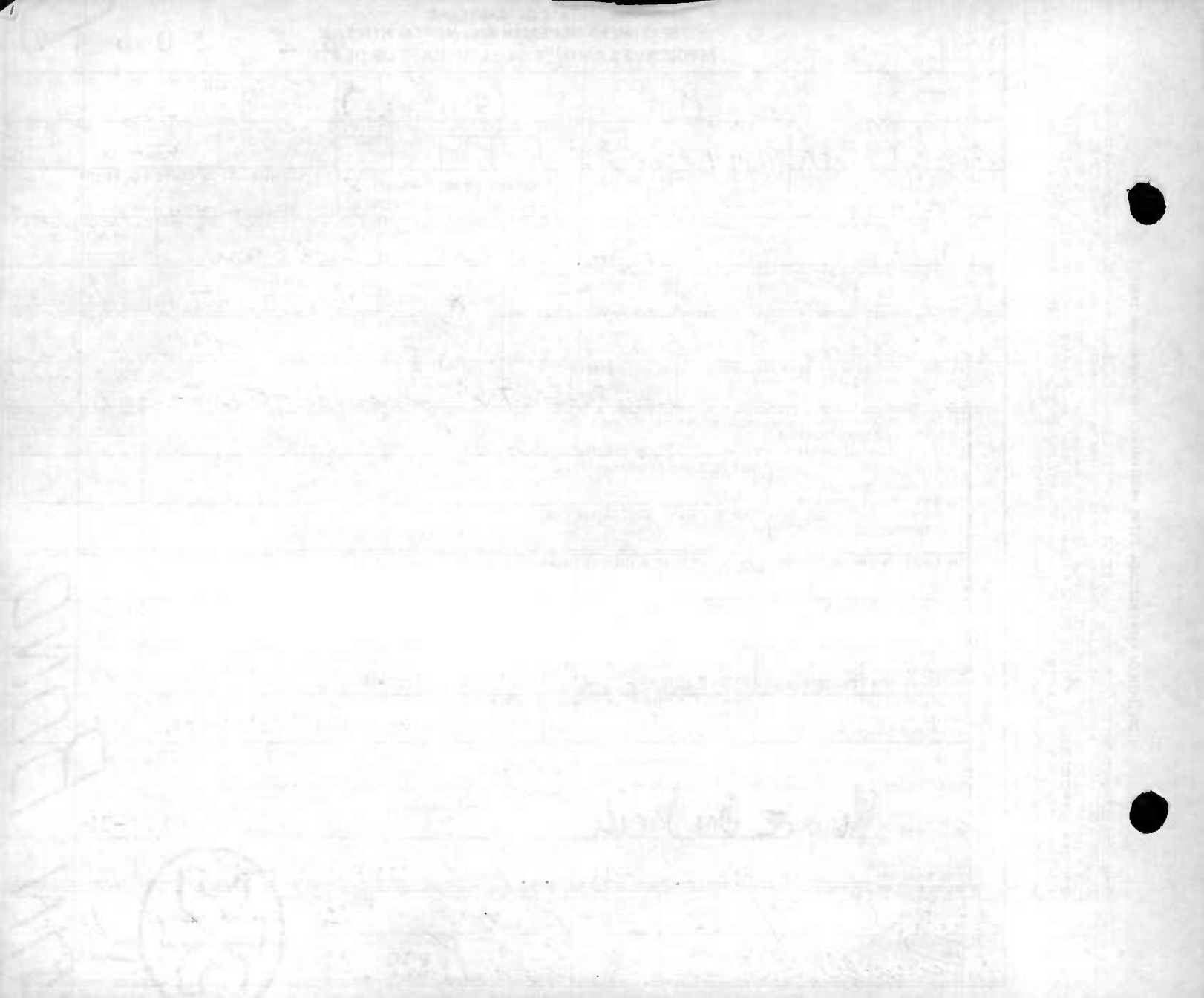
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 6 4 8 REG. NO.					
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) <b>ERNEST NMI MATTHEWS</b>							2a. DATE OF DEATH MONTH DAY YEAR <b>8 26 82</b>		2b. HOUR <b>8 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 23 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ARKANSAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.									
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECURITY</b>		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>					13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>562 Robert Street.</b>				
14. FATHER'S NAME FIRST <b>JOSEPH</b> MIDDLE <b>JOSEPH</b> LAST <b>MATTHEWS</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>MARY</b> LAST <b>SETTLES</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE NUMBER UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>217-16-4134</b>		17. INFORMANT ADDRESS <b>Patricia Johnson 5632 Steven Forest</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary/Cardio Arrest</b> <b>2762</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypoxia, Acidosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes Mellitus</b>															
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (his hospital) attended the deceased from <b>8/25</b> <b>1982</b> to <b>8/26</b> <b>1982</b> , that (I) (we) lost saw the deceased alive on <b>8/26</b> <b>1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>Robert H. Levitt, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8/26/82</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert H. Levitt, M.D.</b>		22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/2/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md Vet. Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownville Md</b>									
24. FUNERAL DIRECTOR NAME <b>William March</b> ADDRESS <b>F/H 1101 E. North</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 31 1982</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 20649	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GREGORY Wm MATTHEWS (Sewell)										2b. DATE KNOWN OF DEATH XX MONTH DAY YEAR 8-31-82	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR May 1 1960	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 22	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8-31-82	24. HOUR 12:16 PM					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7d. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2833 Bookert Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labour		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md - Balto										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Sewell					15. MOTHER'S MAIDEN NAME MIDDLE LAST Virginia Lambill						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 220-80-6037		17. INFORMANT ADDRESS Virginia Matthews 3047 Southland Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stabwound of chest</u> DUE TO, OR AS A CONSEQUENCE OF 9560 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:16PM 8-31-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/inflicted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) basement		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2333 Bookert Drive Baltimore, Maryland					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Maurice One Shell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 8-31-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (BY)		23b. DATE 9/4/82		23c. NAME OF CEMETERY OR CREMATORY St Rest		23d. LOCATION CITY OR TOWN COUNTY STATE Honover AA Md					
24. FUNERAL DIRECTOR NAME ADDRESS Furnell B. Allen - Balto. Md				25a. DATE REC'D. BY REGISTRAR SEP. 2 1982		25b. REGISTRAR'S SIGNATURE John J. Linnick					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

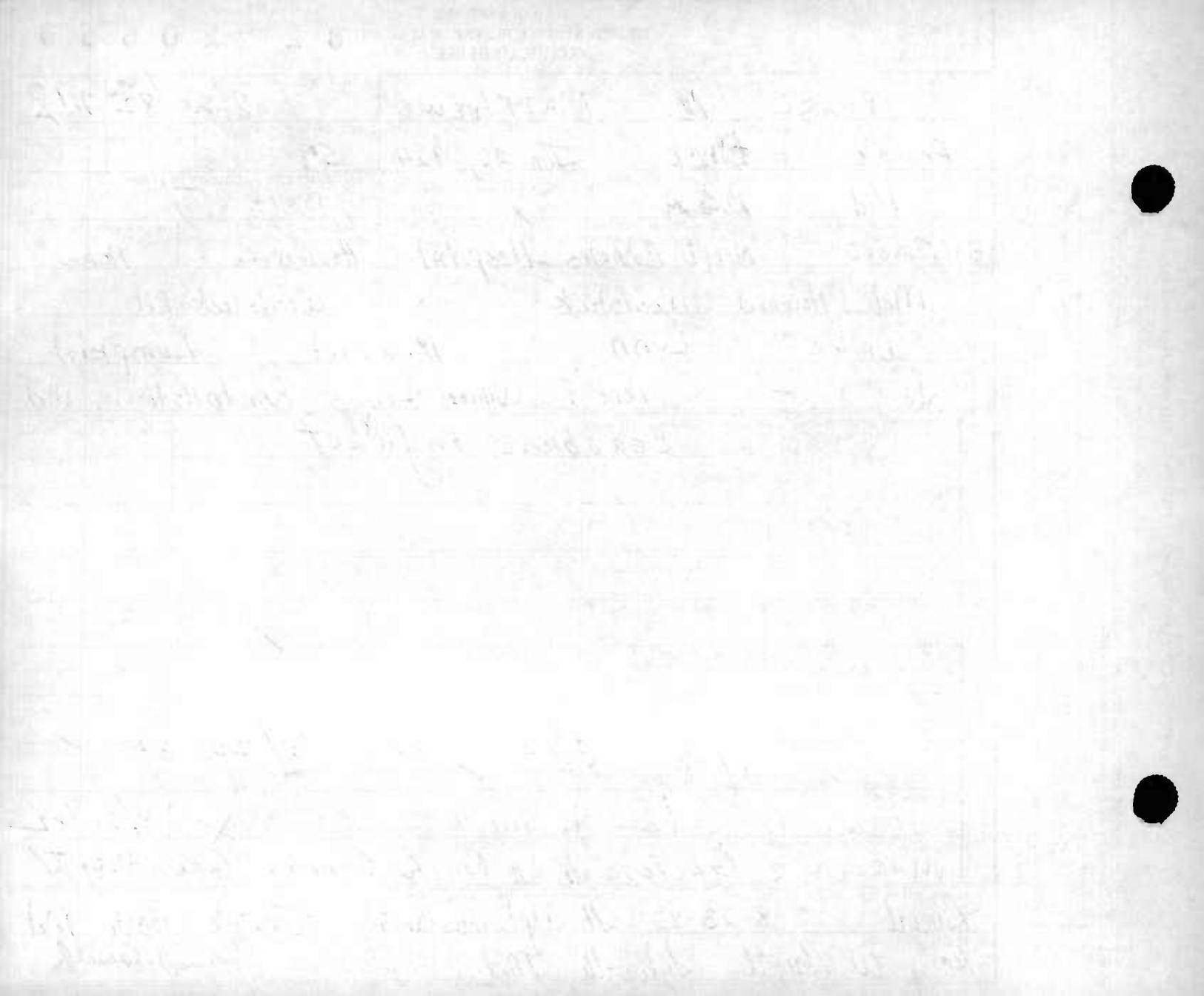
8 2 2 0 6 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PEARL M. MATTHEWS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>8/20/82</b>		2b. HOUR <b>7:10 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 22, 1924</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles Hospital</b>	
12. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. City</b>		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		14. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE 15b. COUNTY 15c. CITY OR TOWN <b>Md. Howard Woodstock</b>		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. STREET ADDRESS <b>Woodstock Rd</b>	
18. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Lynn</b>		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Lumpkin</b>		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
21. SOCIAL SECURITY NO. <b>None?</b>		22. INFORMANT <b>William Griggs - Randallstown, Md</b>		23. ADDRESS	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Infarct</b> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____					
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE	
35. I certify that (i) (this hospital) attended the deceased from <b>8/13</b> 19 <b>82</b> , to <b>8/20</b> 19 <b>82</b> , that (ii) (we) last saw the deceased alive on <b>8/20</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.					
36. SIGNATURE <b>Marcos B. Galicia Jr. M.D.</b>		37. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED <b>8/20/82</b>	
39. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARCOS B. GALICIA Jr. M.D.</b>		40. ADDRESS <b>North Charles Gen. Hosp. /</b>			
41. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		42. DATE <b>8-23-82</b>		43. NAME OF CEMETERY OR CREMATORY <b>St. Alphonsus Center</b>	
44. LOCATION <b>Woodstock</b>		45. CITY OR TOWN COUNTY STATE <b>Balt. Md.</b>			
46. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b>		47. ADDRESS <b>Sylmar, Md.</b>		48. DATE REC'D. BY REGISTRAR <b>AUG 20 1982</b>	
49. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		50. REGISTRAR'S SIGNATURE			

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 20651	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROY MATTOX										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 8 24 1982	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH (MONTH DAY YEAR) 4 3 07		6. AGE (IN YEARS) (LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 8 24 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital (DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 343 Camp St.	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Mattox						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Mae Norman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 240-10-8355		17. INFORMANT ADDRESS Ella White 331 E. 24th St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 8-25-82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8/31/82		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave						25a. DATE REC'D. BY REGISTRAR AUG 31 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

THE UNIVERSITY OF CHICAGO  
LIBRARY



*Handwritten signature or name, possibly "John Doe".*



UNIVERSITY OF CHICAGO LIBRARY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 2 0 6 5 2

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
William Henry Maxwell, Sr.								8 18 19 82								M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male	Cauc.	Dec. 13, 1943		38 YRS.						8 18 19 82								1:10P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Baltimore		USA						Baltimore City, MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		Union Memorial Hospital		Foreman		Beth Steel													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		---		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3742 Elmley Ave, Balto, MD. 21213											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Vernon Maxwell		Mary Alma McCarthy																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
---		220-40-9072		Diane Maxwell, same as above															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last: (b) _____ (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
Ann M. Dixon, M.D.		M.D. Assistant MEDICAL EXAMINER		8/19/82															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
Ann M. Dixon, M.D.		111 Penn St. Balto., MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		8/21/82		Sacred Heart of Jesus, Baltimore, Md.															
24. FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Schimunek Funeral Home 3331 Brehms Lane, 21213		AUG 20 1982		John J. Schimunek															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 82 20653							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Theodore Reginald May				2a. DATE OF DEATH MONTH DAY YEAR 8 14 82		2b. HOUR 11:30 AM	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 12 16 1900		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Maryland			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3030 Gwynns Falls Parkway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffer		12b. KIND OF BUSINESS OR INDUSTRY Pvt. Families	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3030 Gwynns Falls Pkwy Balto., Md. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Mack May				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Gospree					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-22-8789		17. INFORMANT ADDRESS Baltimore, Md. 21216 Pkwy Mrs. Mayfair S. May 3030 Gwynns Falls					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate</u> 1850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-19</u> 19 <u>81</u> , to <u>8-14</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7-1</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE <u>Abraham B. Hurwitz MD</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-17-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Abraham B. Hurwitz				22e. ADDRESS MD 7501 Liberty Road, Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 8/19/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Maryland			
24. FUNERAL DIRECTOR NAME HERBERT E. NUTTER FUNERAL HOME 3035 W. NORTH AVE.				25a. DATE REC'D. BY REGISTRAR AUG 20 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Daniel</u>			



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 5 4  
REG. NO.

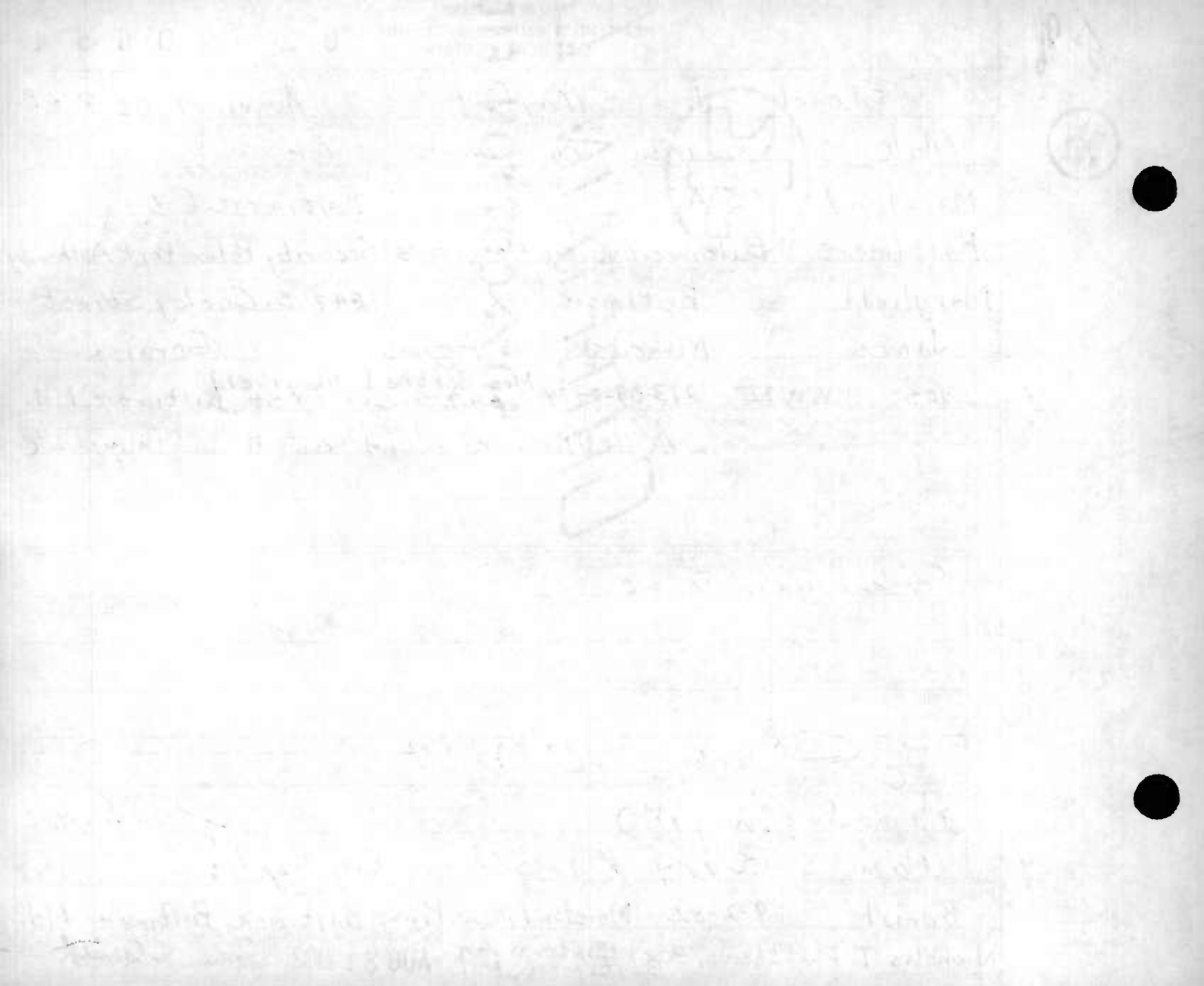
1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Edward J. Mayfield</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 29, 1982</b>		2b. HOUR <b>3:10 P.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06 - 24 - 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Security Police</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Port Authority</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>647 S. Curley Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Makowski</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Goraliski</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>213-09-0374</b>		17. INFORMANT ADDRESS <b>Mrs. Bertha L. Mayfield 647 S. Curley St., Baltimore, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Cerebrovascular Disease</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>29 Aug</b> , 19 <b>82</b> , to _____, 19____, that (I) (we) lost saw the deceased alive on <b>29 Aug</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Wayne S. Barry MD</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>29 Aug 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wayne S. Barry MD</b>			22e. ADDRESS <b>Baltimore City Hospitals</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9-2-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Md.</b>		
24. FUNERAL DIRECTOR (NAME) <b>Nicholas T. Matthews, 3031 Eastern Ave. Baltimore, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>AUG 31 1982</b>				
					25b. REGISTRAR'S SIGNATURE <b>Joan J. Canale</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



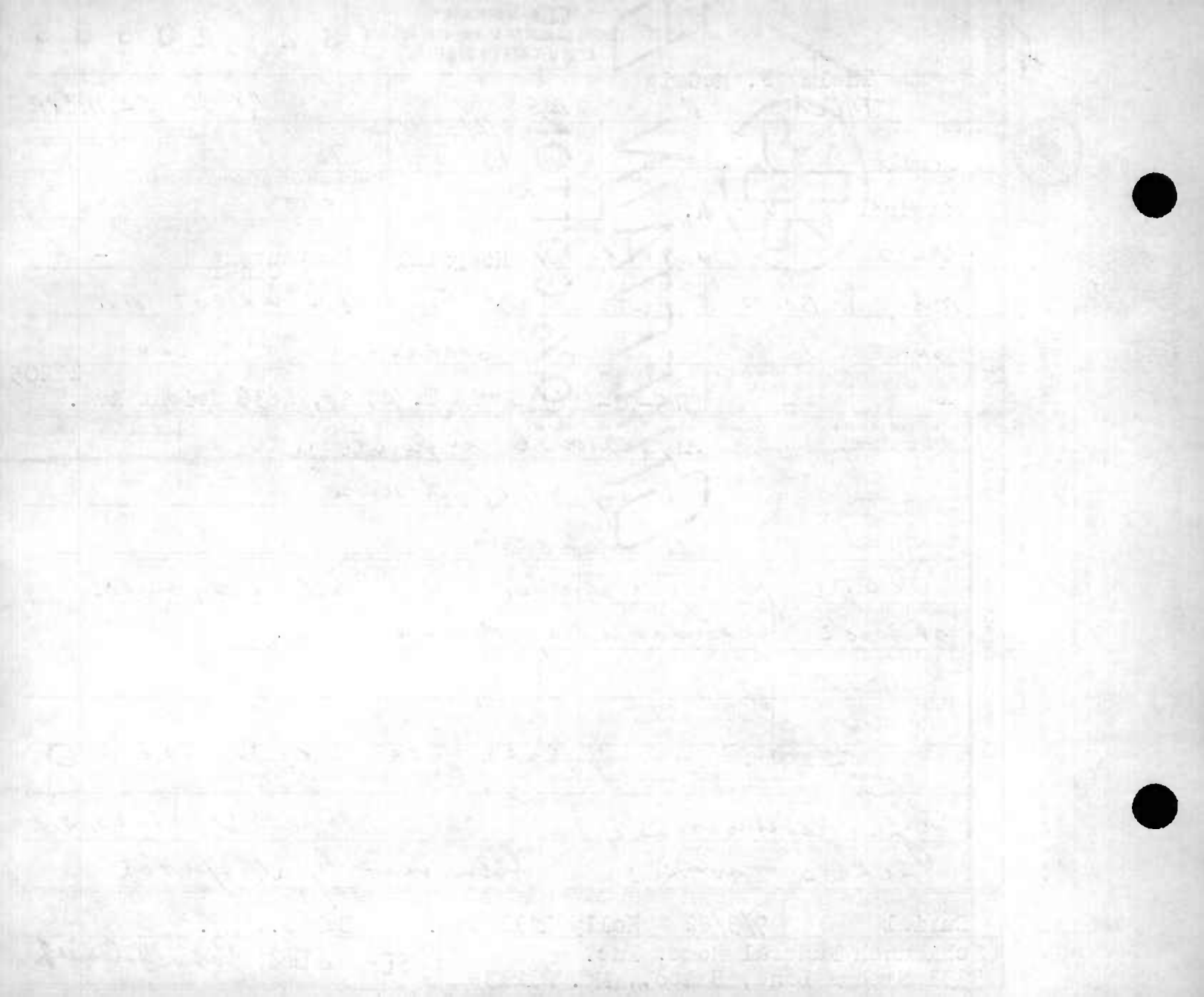
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 0 6 5 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Thelma F. McCaig</b> <b>THELMA F MCCAIG</b>				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <b>08 30 82 11:38 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH 2/10/07 MONTH DAY YEAR <b>02 10 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U-S-A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurant Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13e. STREET ADDRESS <b>4836 WRIGHT AVE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GABRIELA UNK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>-</b>		16b. SOCIAL SECURITY NO. <b>349-01-6461</b>		17. INFORMANT ADDRESS <b>David T. McCaig, 4836 Wright Ave. 21205</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>COPD, peripheral vascular disease pulmonary emboli</b>							
19a. DATE OF OPERATION <b>08-30-82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>coronary artery disease</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>21d. INJURY OCCURRED</b> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-28</b> 19 <b>82</b> to <b>8-30</b> 19 <b>82</b> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <b>8-30</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sergio TAVARES, M.D.</b>				DEGREE <b>PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8-30-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SERGIO TAVARES</b>				22e. ADDRESS <b>University Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/3/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 2 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	
3331 Brehms Lane, Balto., Md. 21213							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>William Hugh McCall</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>8 24 82</b>				2b. HOUR <b>5:42 P.M.</b>	
3 SEX <b>Male</b>		4 RACE <b>Cauc</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 24 12</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NECESSARY, GIVE STREET ADDRESS) <b>South Balto. Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saw operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Box &amp; Paper</b>			
13a. STATE <b>Md.</b>						13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hugh McCall</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Spencer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>Yes WWII</b>				16b. SOCIAL SECURITY NO. <b>212-07-3165</b>		17 INFORMANT ADDRESS <b>Clara McCall (same as 13e)</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Cardio-respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <b>8-19</b> , 19 <b>82</b> , to <b>8-24</b> , 19 <b>82</b> , that (a) we last saw the deceased alive on <b>8-24</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (b) we (did) (did not) view the body after death.											
22b. SIGNATURE <b>M. Nestor</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8-24-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. Nestor M.D.</b>						22e. ADDRESS <b>3001 S. Hanover St., Balt., M.D.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/28/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>					
24 FUNERAL DIRECTOR NAME <b>George J. Gonce F.H. 4001 Ritchie Hwy.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			



*[Faint, illegible handwritten notes and markings are visible across the page.]*

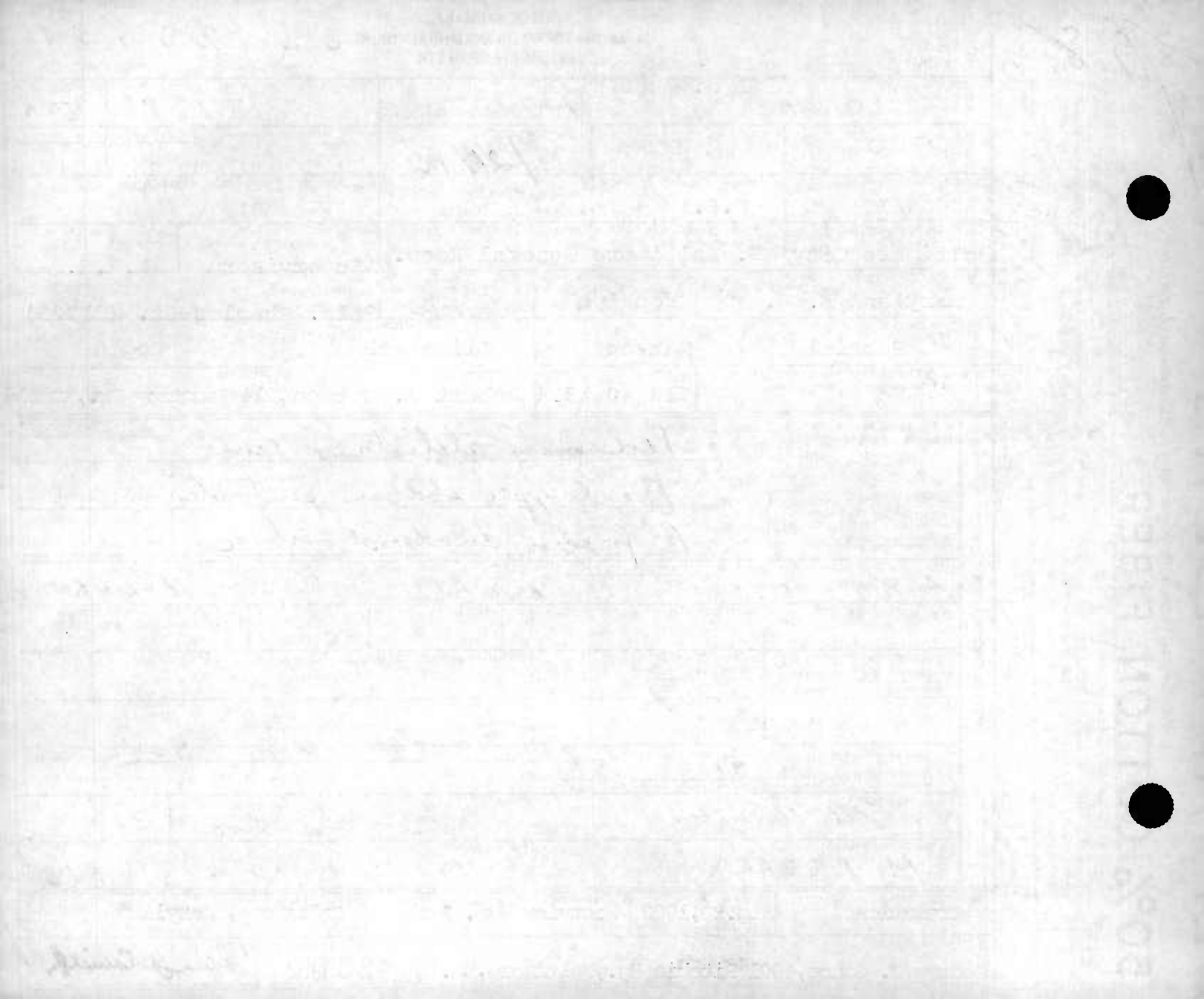
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 5 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>OLGA M. McCLINTOCK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>8 19 82</b>		2b. HOUR <b>959 A</b>	
3 SEX <b>FEMALE</b>	4. RACE <b>W HITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 / 21 / 1909</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WISCONSIN</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b>		10 CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>S. Baltimore General Hosp.</b>	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b KIND OF BUSINESS OR INDUSTRY <b>I.R.S.</b>		13a STREET ADDRESS <b>211E. Charles St. (21225)</b>	
13b INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c CITY OR TOWN <b>Brooklyn</b>		13d STATE <b>Maryland</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Gabriel Matson</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Cogen</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b SOCIAL SECURITY NO. <b>212 40 1324</b>		17 INFORMANT <b>Robert J. Matson</b>		ADDRESS <b>214 Dauntsey Dr., Arnold Md.</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>5325</b> IMMEDIATE CAUSE (a) <b>Pulmonary atelectasis, severe</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>focal upper Abdomen peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Perforated duodenal ulcer</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ALCOHOLISM, SEPSIS, MI, ASPIRATION, SEIZURES, BRAIN ANOXIA</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>8/11</b> 19 <b>82</b> , to <b>8/19</b> 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>8/19</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M. McCarthy</b>		DEGREE		22c. DATE SIGNED <b>8/19/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. MCCARTHY</b>		22e ADDRESS <b>3001 S. HANOVER ST. BALC.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL <b>Cremation</b>		23b. DATE <b>Aug. 20, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>	
23d. LOCATION <b>Baltimore, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>AUG 23 1982</b>		23f. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	
24 FUNERAL DIRECTOR NAME <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hg., Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 23 1982</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 2 0 6 5 8							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD John McCoy, Jr.				2a. DATE OF DEATH MONTH DAY YEAR 8 16 82		2b. HOUR 4:52 A.M.			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 6 24		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.			
12. CITY OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Supervisor Westinghouse		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD 16b. CITY OR TOWN Balto				17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS 503 Hammershine Rd			
19. FATHER'S NAME FIRST MIDDLE LAST Edward J. McCoy, Sr.				20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Carter					
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes WWII				22. SOCIAL SECURITY NO. 220-14 4224		23. INFORMANT ADDRESS Rosa McCoy 503 Hammershine Rd Owings Mills, Md.			
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL Infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED				26a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
27d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		27e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27f. LOCATION STREET CITY OR TOWN COUNTY STATE					
28. I certify that (I) this hospital attended the deceased from 8-14-1982 to 8-16-1982, that (I) lost saw the deceased alive on 8-16-1982, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
29. SIGNATURE Charles Levin		DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				30. DATE SIGNED 8-16-82			
31. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Levin		32. ADDRESS Sinai Hospital							
33a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		33b. DATE Aug 19, 1982		33c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		33d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Md.			
34. FUNERAL DIRECTOR H. E. Blauvelt		ADDRESS Owings Mills, Md.		35. DATE REC'D. BY REGISTRAR AUG 20 1982		36. REGISTRAR'S SIGNATURE John J. Canich			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical examiner's report must be attached to this certificate.

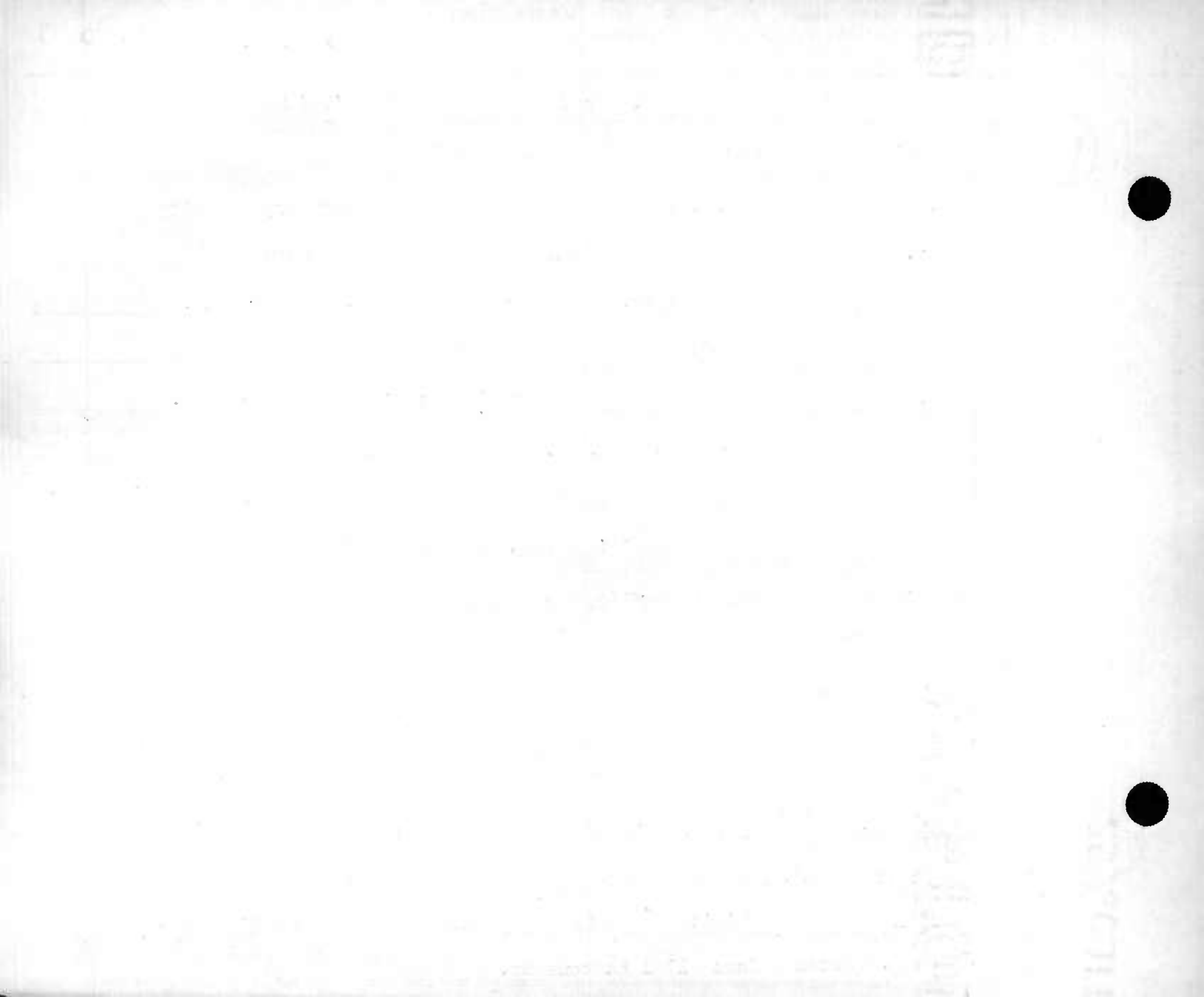
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 6 5 9 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>GERALDINE MCCOY</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>8 8 16 82</b>		2b. HOUR <b>405 PM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BIK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 - 23 - 44</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>38</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>G.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1119 White lock St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James McCoy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CARRIE THOMAS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>ANNETTE THOMAS 504 LAURENS ST.</b>					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b> <b>4512</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>probable metabolic acidosis</b> <b>probable pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>probable cellulitis thrombosis Lt leg</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-16</b> , 19 <b>82</b> , to <b>8-16</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Sher Afzal Hashmi</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHER AFZAL HASHMI</b>						22e. ADDRESS <b>PROVIDENT HOSPITAL BALTIMORE MD 21</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alhmtg G.A.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Vernon R. Bailey 1348 N. Calhoun St.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 24 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 6 6 0			
1- FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Edward S. McCray					2a. DATE OF DEATH 8/29/82				2b. HOUR M				
3 SEX Male		4 RACE Black		5. DATE OF BIRTH 4 15 1928		6 AGE (IN YEARS LAST BIRTHDAY) 54		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10 CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3935 Rokeby Rd.		
14 FATHER'S NAME FIRST MIDDLE LAST Henry MC Gray					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lou Rose								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS Maxine McCray 3935 Rokeby Rd.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Death</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease, CITE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>block Pulmonary Emboli</u>													
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET -		CITY OR TOWN -		COUNTY -		STATE -			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-16</u> , 19 <u>82</u> , to <u>8-17</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Louis J. Domenech</u>				DEGREE MD				22c. DATE SIGNED 9/2/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis J. Domenech				22e. ADDRESS 500 Broad Ave Balto 1701 21216									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/2/82		23c. NAME OF CEMETERY OR CREMATORY King Mem. Park		23d. LOCATION CITY OR TOWN Randallstown, Md.		COUNTY -		STATE -			
24 FUNERAL DIRECTOR NAME James A. Morton & Sons				ADDRESS 1701 Laurens St.		25a. DATE REC'D. BY REGISTRAR SEP 8 1982							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 2 0 6 6 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>James</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 17 82</b>		
3 SEX <b>Male</b>			2b. HOUR <b>7:15 P.M.</b>		
4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 11 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>45 South Kossuth Street</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, Maryland MD.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Oiler</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Richardson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>248-10-8690</b>		17. INFORMANT <b>Baltimore, Md. 21229</b> <b>Mrs. Mary E. McCray 45 S. Kossuth St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>4360</b> IMMEDIATE CAUSE (a) <b>STROKE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>YEARS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CARDIAC BLOCK; CHRONIC OBSTRUCTIVE LUNG DISEASE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 19 82</b> to <b>8/17 19 82</b> , that (I) (we) lost saw the deceased alive on <b>8/5 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Walter J. Alt, MD</b>		DEGREE		22c. DATE SIGNED <b>8/10/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Walter J. Alt.</b>		22e. ADDRESS <b>301 MARYDELL RD, BALTIMORE, MD 21229</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/21/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>BALTIMORE, MARYLAND 21226</b> <b>HERBERT E. NUTTER FUNERAL HOME 3035 W. NORTH AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 20 1982</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>	



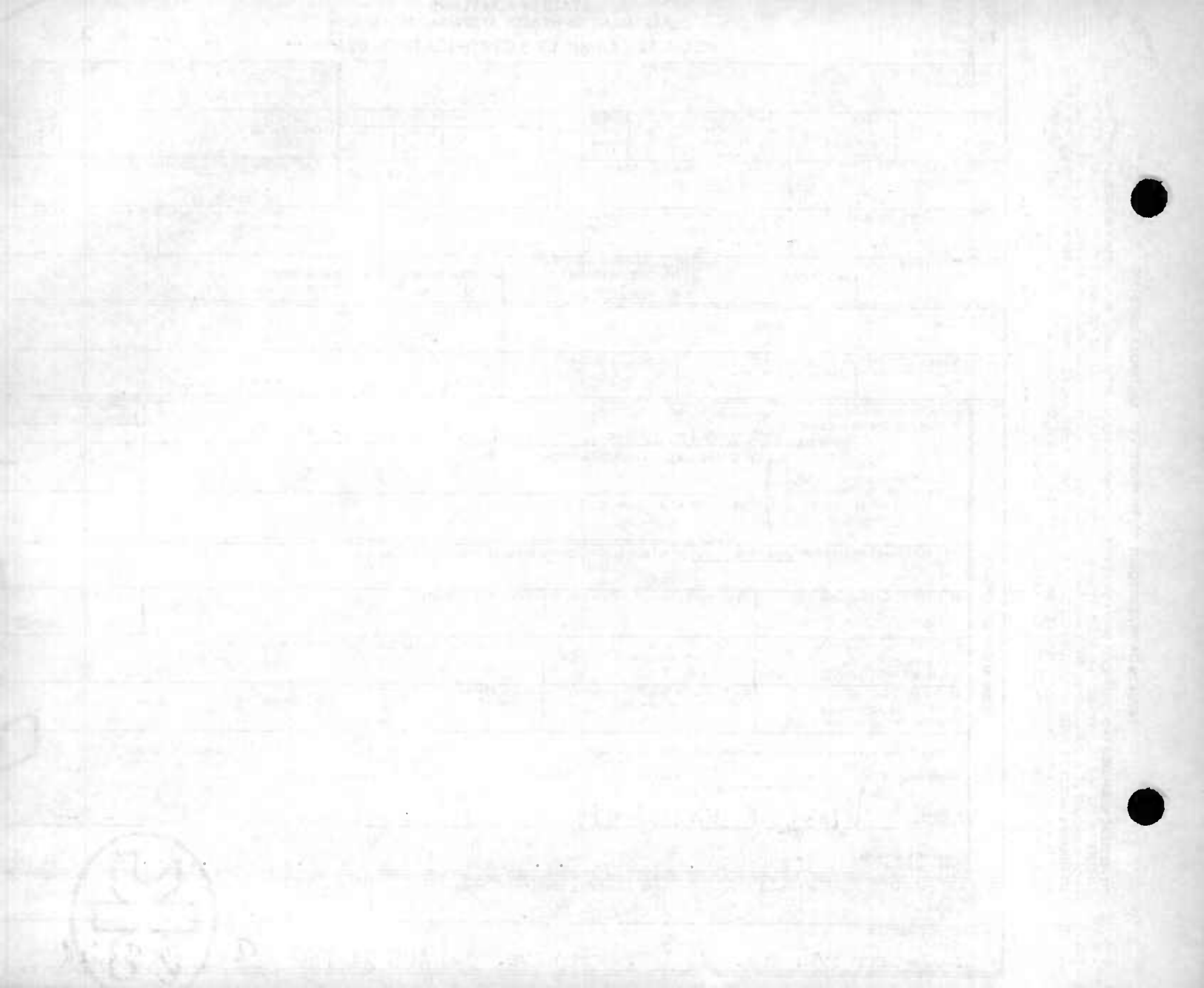
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20662

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Mann		MIDDLE McCray		LAST McCray		2a. DATE KNOWN OF DEATH MATED		MONTH 8		DAY 24		YEAR 1982		2b. HOUR 1:09			
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9/1/12		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 24 1982									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.				13b. COUNTY Balto.				13c. CITY OR TOWN Balto.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2216 Brunt St.					
14. FATHER'S NAME FIRST MIDDLE LAST Unkn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkn				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT ADDRESS Lillie McCray 2216 Brunt St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												DATE SIGNED 8-24-82					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/28/82				23c. NAME OF CEMETERY OR CREMATORY Church Cem.				23d. LOCATION CITY OR TOWN Addor, N.C.				COUNTY STATE					
24. FUNERAL DIRECTOR NAME Wm C March F/H, Inc.				ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR AUG 26 1982				25b. REGISTRAR'S SIGNATURE John J. Connel									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 6 6 3 REG. NO.					
1. FOR STATE REGISTRAR						1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANNIE L. McDANIEL</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>8 1 82</b>		2b. HOUR <b>1 AM</b>	
3 SEX <b>FEMALE</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 9 1886</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>95</b>		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 72 HRS. HOURS MIN. <b>0 0</b>					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD. MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>									
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>965 ELLIOTT DRIVEWAY</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>212-10-9941</b>		17. INFORMANT ADDRESS <b>MRS. SHIRLEY WILSON 965 ELLICOTT DRIVE WAY</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF GALL BLADDER</b> <b>1560</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ASCVD</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION <b>8/1/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ASCVD</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/1 19 82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) <b>ASCVD</b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>HOME</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>											
22a. I certify that I (this hospital) attended the deceased from <b>8/1 19 82</b> to <b>8/1 19 82</b> , that I saw the deceased alive on <b>8/1 19 82</b> and that in my opinion death occurred on the date and hour and from the causes stated above. <b>Howard B. Chen, M.D.</b> did not view the body after death.										22b. SIGNATURE DEGREE <b>Howard B. Chen M.D.</b>		22c. DATE SIGNED <b>8/1/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HOWARD B. CHEN, M.D.</b>				22e. ADDRESS <b>BON SECOURS HOSPITAL</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8/5/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE (AA Co.) MD.</b>									
24. FUNERAL DIRECTOR NAME <b>LEWIS T. GWYNN</b>				ADDRESS <b>4517 PARK HEIGHTS AVENUE 21215</b>		25a. DATE REC'D BY REGISTRAR <b>AUG - 2 1982</b>									

BURIAL 3/2/32 GEORGE HILL CEMETERY BARTIMORE (A. CO.) MD.

Handwritten notes and signatures, including "Hill" and "George Hill Cemetery".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

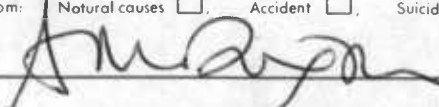

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
Item 13a&e Phone 1- STATE 8-25-82 cn REGISTRAR									
8 2 2 0 6 6 4 CERTIFICATE OF DEATH REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		2b. HOUR	
BB McDaniel						6 22 82		4 10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Black		6 19 82		700 YRS.		MONTHS 3 DAYS 3 HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore		Baltimore				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Baltimore City Hosp							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS		13b. CITY OR TOWN	
13a. STATE Maryland						6530 Falkirk Rd		21239	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME			
300 Gary Tyrone Taylor						Donna McDaniel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 7690 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>severe hyaline membrane disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/20/82</u> 19 <u>82</u> , to <u>6/22/82</u> 19 <u>82</u> , that (I) (we) lost <u>saw the deceased alive on 6/22/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Renee A. Cousins</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>6/22/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Renee A. Cousins</u>				22e. ADDRESS <u>550 N. Broadway</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <u>City Hosp</u>				ADDRESS		25a. DATE REC'D. BY REGISTRAR <u>AUG 19 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

1-11-55  
1-11-55

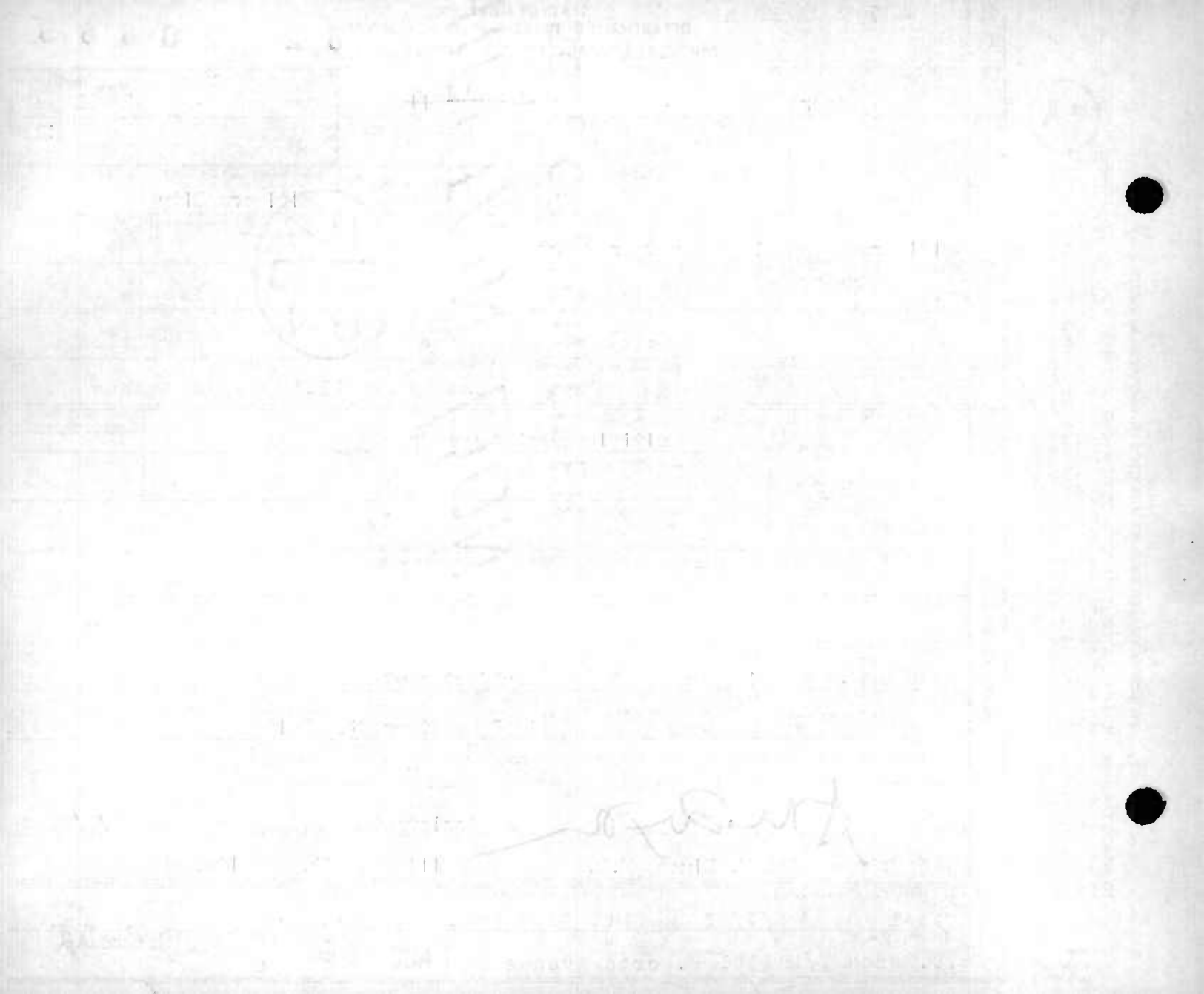
1-11-55  
1-11-55

1-11-55

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

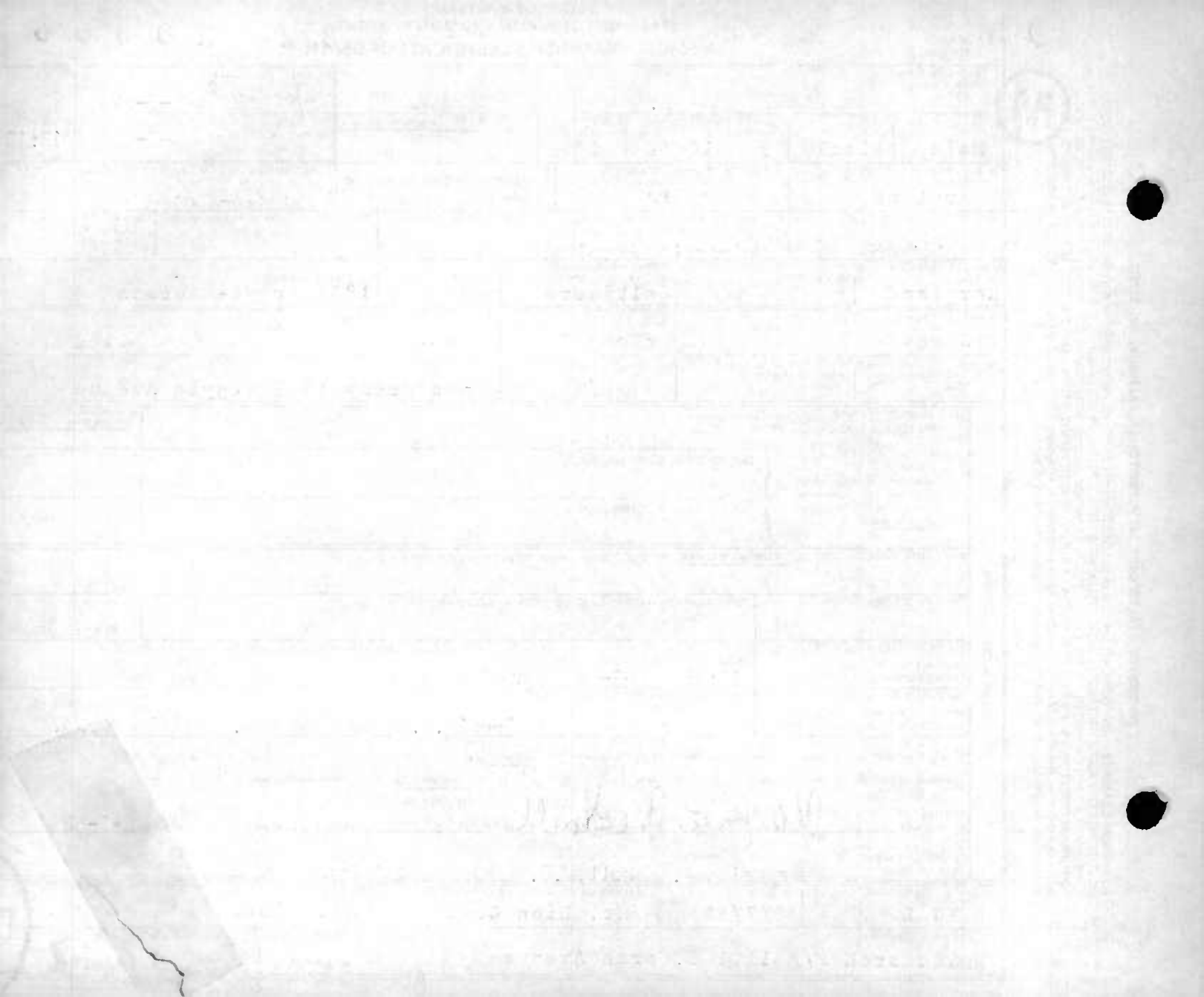
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 20665	
1. DECEASED NAME (TYPE OR PRINT) <b>Andre D. McDougall</b>										2a. DATE OF DEATH KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>11</b> YEAR <b>62</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>19</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>2</b> YEAR <b>1982</b>		2b. HOUR <b>12:45</b> a <input type="checkbox"/> m <input type="checkbox"/>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1427 Mountmor Court</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1335 Argyle Avenue</b>			
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>McDougal</b> LAST <b>McDougal</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Emma</b> MIDDLE <b>Allen</b> LAST <b>Allen</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Emma McKoy 1335 Argyle Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9654</b> IMMEDIATE CAUSE (a) <b>Multiple gunshot wounds</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12:30xx 8 2 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject shot</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET <b>1427 Mountmor Ct.</b> CITY OR TOWN <b>Balto.</b> COUNTY <b>Balto.</b> STATE <b>Md.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>M.D. Assistant</b>				MEDICAL EXAMINER		DATE SIGNED <b>8/2/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St. Balto., MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8/7/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b>		23d. LOCATION CITY OR TOWN <b>Mt. Zion</b> COUNTY <b>Md.</b> STATE <b>Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Avenue</b> ADDRESS				25a. DATE REC'D BY REGISTRAR <b>AUG - 5 1982</b>		25b. REGISTRAR'S SIGNATURE 					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 20666	
1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
		JAMES A. MCDOUGAL				8-3-82		19		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male		Black		MONTH DAY YEAR 5 10 58		LAST BIRTHDAY 24 YRS.		MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD	
										8-3-82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				2d. HOUR	
Maryland		USA				Baltimore City				12:10 M	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		University Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland				Baltimore				1335 Argyle Avenue			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
James		Emma Allen		No		N/A		Emma McKoy		1335 Argyle Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
9654		IMMEDIATE CAUSE (a) Multiple gunshot wounds									
		DUE TO, OR AS A CONSEQUENCE OF									
		(b)									
		DUE TO, OR AS A CONSEQUENCE OF									
		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM TB PART 1 OR PART 2)							
		11:25PM 8-2-82		subject shot							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
		street		1800blk.W. Fairmount Ave. Baltimore, Md.							
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Margarita A. Koroll, M.D.		Assistant		8-3-82							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		8/7/82		Mt. Zion Cem.		Mt. Zion, Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. C. March		F/H 1101 E. North Avenue		AUG - 5 1982		John J. Canich					



Items #18a-22a Film G57d 9/30/82  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 0 6 6 7

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
JEFFREY		McFADDEN						8-30-82				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		11:00 PM	
m	B	4-3-1976		6 YRS.						8-30-82		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.	
Md		U.S.A				Baltimore City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		University Hospital											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md		BALTO				YES <input type="checkbox"/> NO <input type="checkbox"/>		1202 W. Mosher St					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Emmanuel		Hazel											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
				Thelmadine Tyler		Thelmadine Tyler - Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Subdural hematoma													
8880													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				? P.M. 8/26/1982				subject fell					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION					
				playground				Baltimore Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Margarita A. Korell, M.D.				M.D. Assistant				8-31-82					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Margarita A. Korell, M.D.				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				9/3/82		Mt Auburn				BALTO, Md			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
V.R. Bailey				1348 N. CALHOUN ST				SEP, 2 1982				John J. Lough	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text block]

[illegible text block]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 6 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEROY MCFADDEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8/14/82</b>		2b. HOUR <b>9:58 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 8 15</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		7. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.		8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>		
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>541 N. Pulaski ST.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Reid McFadden</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amelia McFadden</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>261-26-6761</b>		17. INFORMANT <b>Daniel McFadden</b>		ADDRESS <b>541 N. Pulaski St.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>@ARDS 2° to ASPIRATION PNEUMONIA @ Squamous CA tongue s/p red neck</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Valerie Sorkin-Wells</b>		DEGREE <b>MD.</b>		22c. DATE SIGNED <b>8/14/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VALERIE SORKIN-WELLS, MD.</b>		22e. ADDRESS <b>C/O SINAI HOSP. OF BALTIMORE</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/19/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Chas.A.Rice FHPA 1300 Eutaw Pl.</b>				
25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Linnick</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 23c, 23d #G571 9/7/82 ph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 2 2 0 6 6 9

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Jane McFarlane</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 29, 1982</b>		2b. HOUR <b>11:05pm</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 27 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Trinidad</b>		7b. CITIZEN OF WHAT COUNTRY? <b>W. Indies</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1627 E. 33rd St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edgar Pasqual</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pholomine Formerly</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-62-9816</b>		17. INFORMANT ADDRESS <b>Joseph McFarlane 1627 E. 33rd St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1519 Metastatic Carcinoma of Stomach</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>August 13, 1982</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of the stomach</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from <b>July 4, 1982</b> to <b>August 29, 1982</b> that (X) (we) last saw the deceased on <b>August 29, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Travis</i>				DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>8-30-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jetti Prasad, M.D.</b>				22e. ADDRESS <b>C/O Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/2/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem. - King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN STATE <b>Anne Arundel Co. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 1 1982</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i>			



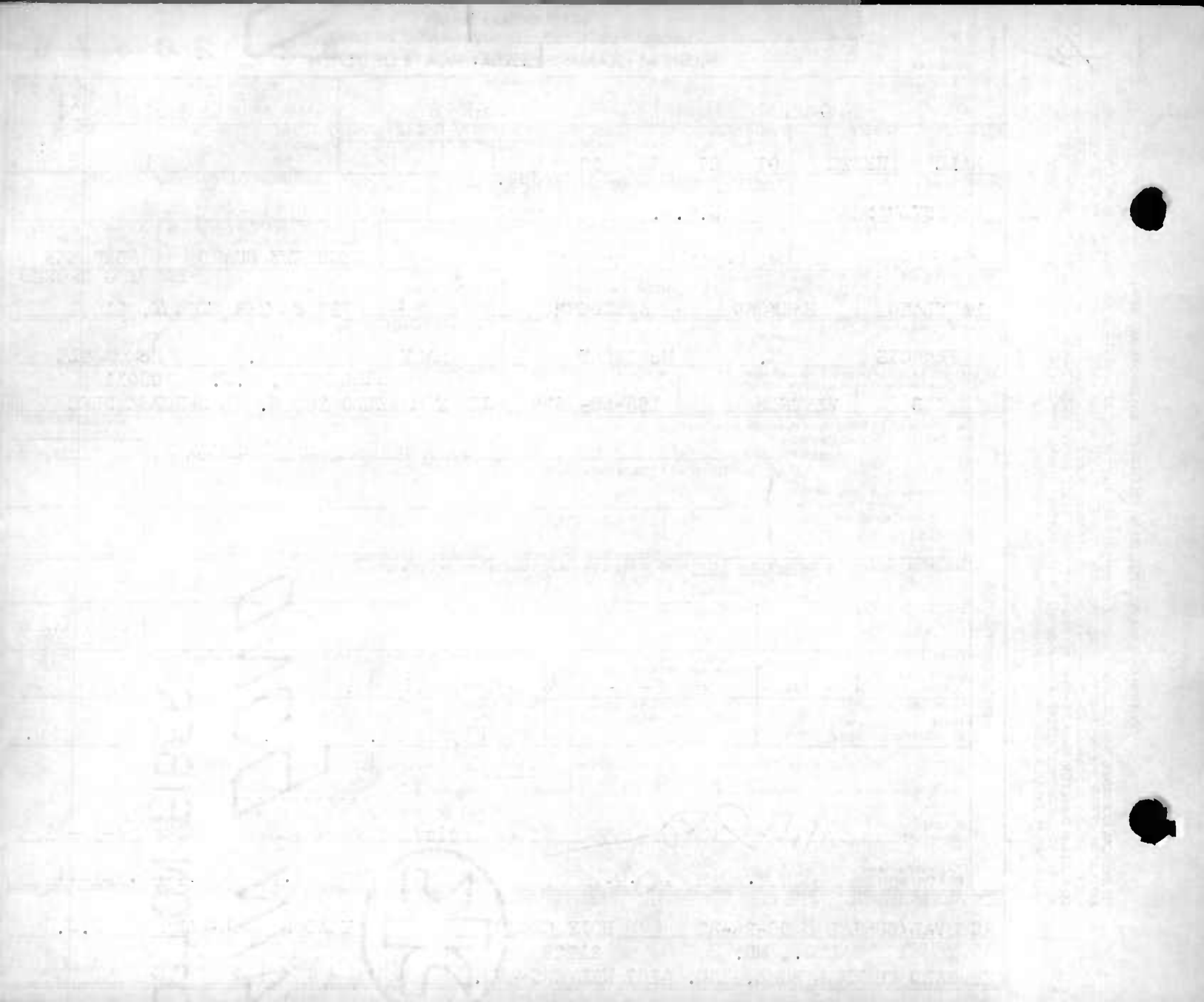
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 20670	
1. DECEASED NAME (TYPE OR PRINT) THOMAS MC GINLEY										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8 18 19 82		2b. HOUR M a M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 07 50		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 18 19 82		2d. HOUR 5:53 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. Marital Status MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY GUARD				12b. KIND OF BUSINESS OR INDUSTRY ABERDEEN PROVING GROUND	
13a. STATE MARYLAND		13b. CITY OR TOWN HARFORD		13c. CITY OR TOWN ABERDEEN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 718 PLATER STREET, 21001					
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS X. MCGINLEY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. McMONAGLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES VIETNAM				16b. SOCIAL SECURITY NO. 196-40-4639		17. INFORMANT ADDRESS BELL MAWR, N.J. 08031 JIM TOMASELLO 200 S. BLACKHORSE PIKE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9854 IMMEDIATE CAUSE (a) Gunshot wound of abdomen (unspecified weapon) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? BODY ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR XX 8-18- 19 82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 718 Plater St. Aberdeen Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .													
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 8-18-82	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL				23b. DATE 08-24-82		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS				23d. LOCATION CITY OR TOWN COUNTY STATE YEADON DELAWARE N.J.			
24. FUNERAL DIRECTOR NAME BALTO., MD. ADDRESS 21229 HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.						25a. DATE REC'D. BY REGISTRAR AUG 23 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

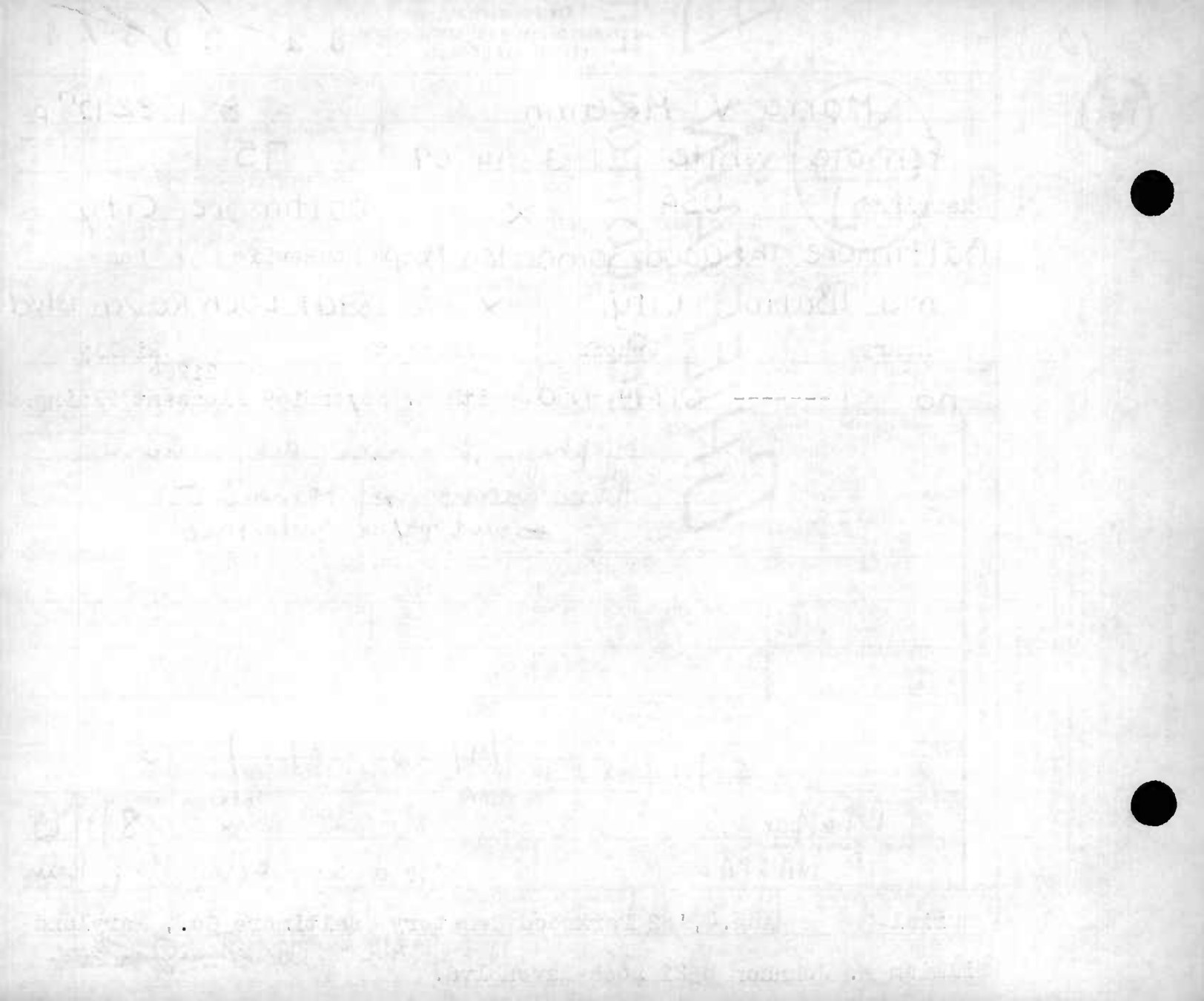
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 7 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Marie V McGinn								8		1		82		12		PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
female		white		3 14 07		75 YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		USA				Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		The good Samaritan Hosp		Housewife		Home											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS											
md Balto		21204		YES NO <input checked="" type="checkbox"/>		8407 B Loch Raven Blvd											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Henry Uphoff		Elizabeth Rielly															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		219-74-4250		Judith E. Soper		21204											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I. DEATH WAS CAUSED BY:																	
1519 IMMEDIATE CAUSE (a)																	
Dysphagia, carcinoma, dehydration																	
DUE TO, OR AS A CONSEQUENCE OF (b)																	
Adenocarcinoma of stomach																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
widespread metastases																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION													
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from		6/9/1982		to		8/1/1982		that (I) (we) last saw the deceased alive on		8/1/1982		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE		DEGREE MD		22c. DATE SIGNED													
Bhagpal				8/1/82													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
B. NAGPAL		Good Samaritan Hosp Balto															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		Aug. 4, '82		Parkwood Cemetery		Baltimore Co., Maryland											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
William E. Johnson		AUG - 2 1982		Name of Registrar													
NAME		ADDRESS															
8521 Loch Raven Blvd.																	

0000 BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 0 6 7 2				
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR				
DONALD JOSEPH MCGREEVY					8 13 82					12:15am				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR					
MALE		WHITE		MONTH 06 DAY 29 YEAR 22			60 YRS.		IF UNDER 24 HRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
WEST VIRGINIA		U.S.A.					BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		ST. AGNES HOSPITAL					LATHE OPERATOR		KOPPERS CORP.					
13a. STATE											13b. CITY OR TOWN	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND											BALTIMORE	ARBUTUS	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	907 S. BEECHFIELD AVENUE, 21229
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST FRANCIS					FIRST MIDDLE LAST ELLA KESBEKER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
NO					185-18-8088		VIVIAN C. MCGREEVY				21229 907 S. BEECHFIELD AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) PULMONARY THROMBOEMBOLY DUE TO, OR AS A CONSEQUENCE OF (b) MURAL THROMBI OF CARDIAC ATRIA DUE TO, OR AS A CONSEQUENCE OF (c) CARDIOMYOPATHY WITH ARRHYTHMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE					DEGREE					22c. DATE SIGNED				
BERT F. MORTON					M.D.					8/13/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
BERT F. MORTON					ST. AGNES HOSPITAL, 900 S. CATON AVENUE									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL					08-16-82		LOUDON PARK			BALTIMORE CITY MARYLAND				
24. FUNERAL DIRECTOR NAME					ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
HUBBARD FUNERAL HOME, INC.					4107 WILKENS AVE.			21229 AUG 16 1982		John J. Conish				





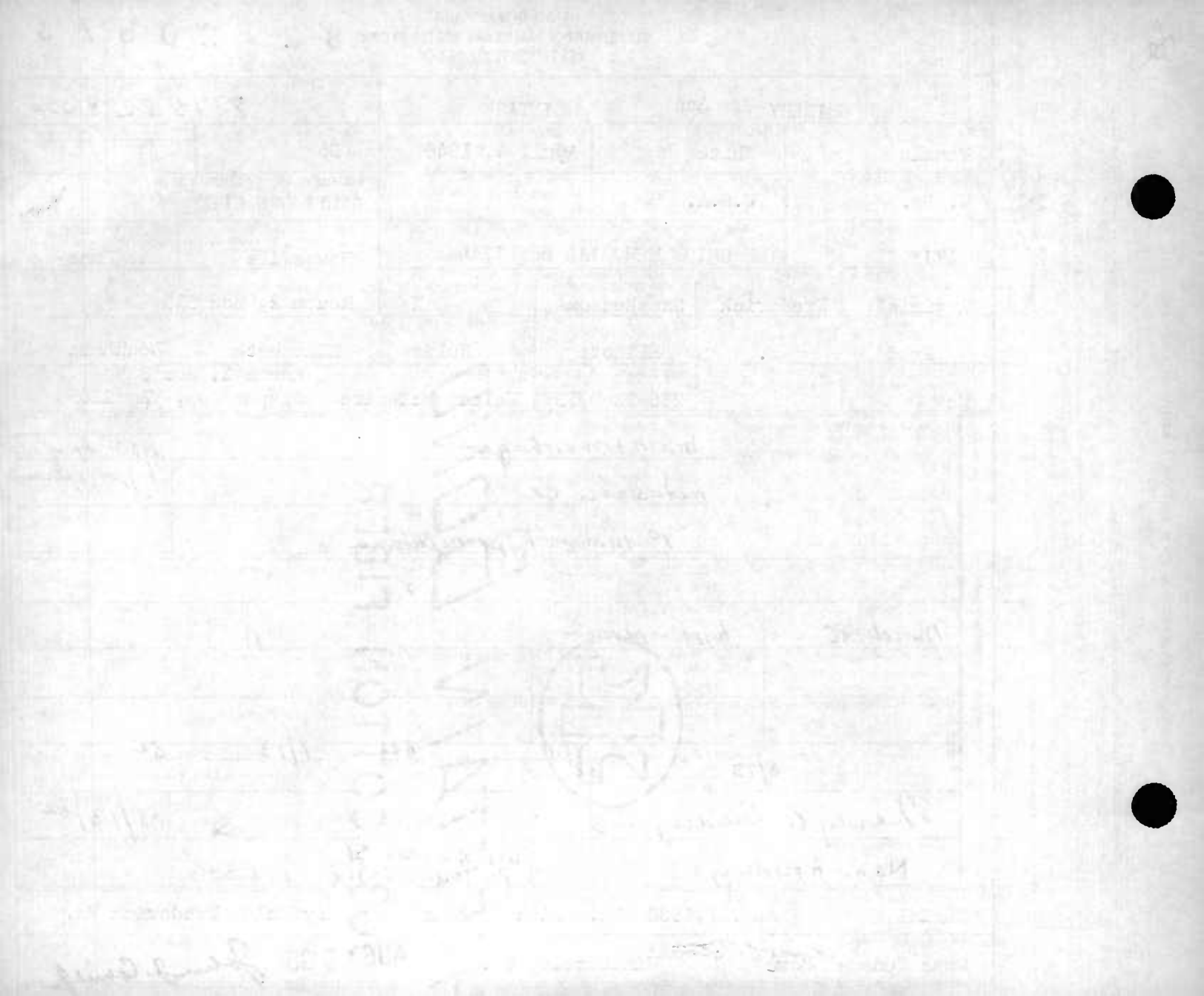
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of

MEDICAL CERTIFICATION

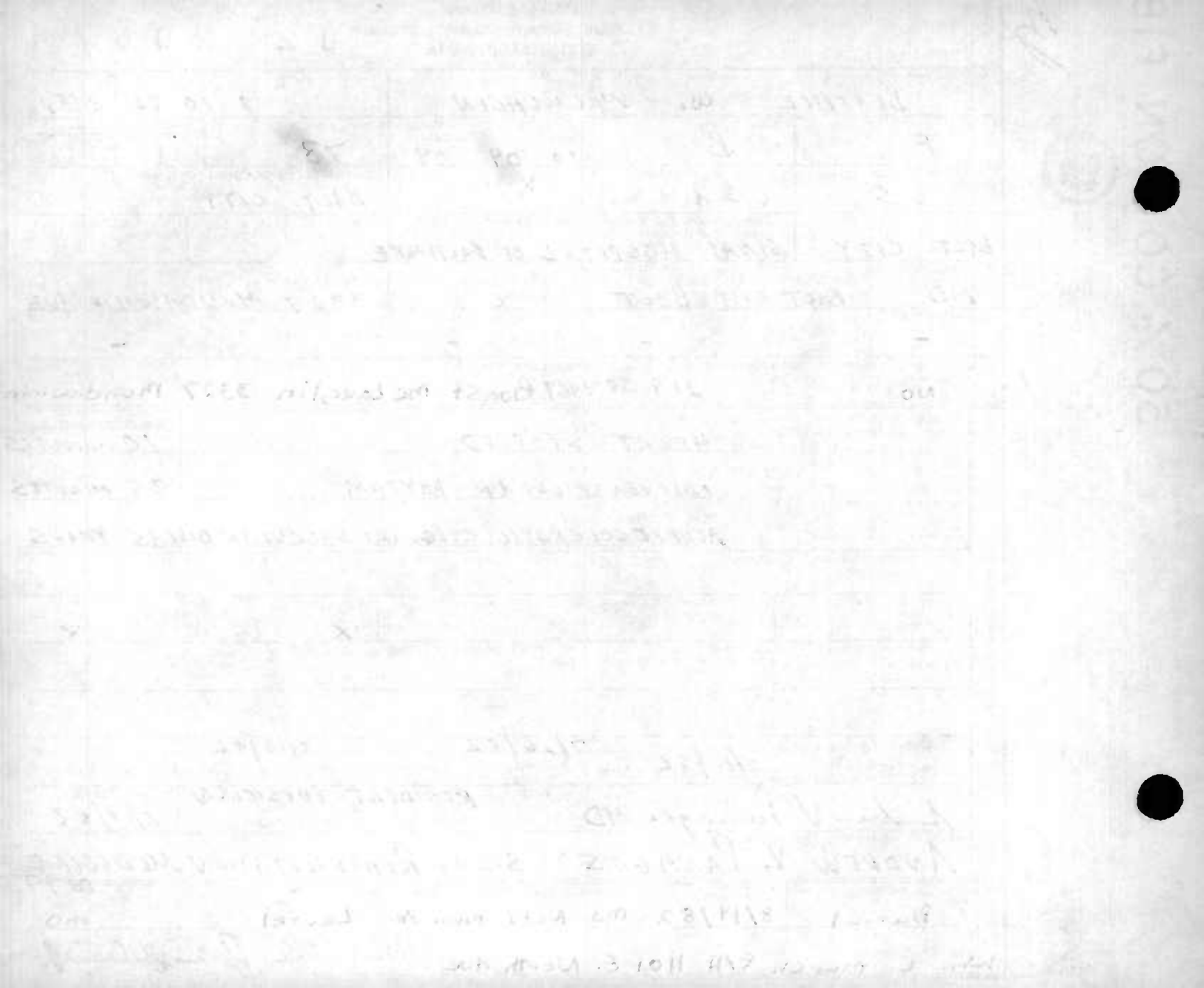
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 0 6 7 3			
FOR 1 - STATE REGISTRAR										CERTIFICATE OF DEATH			
1. DECEASED NAME										2a. DATE OF DEATH			
FIRST MIDDLE LAST										MONTH DAY YEAR HOUR			
SHIRLEY Ann MCINTIRE										8 13 82 8:00 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS.			
Female		White		April 4, 1946		36		MONTHS DAYS		HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		THE UNION MEMORIAL HOSPITAL				Housewife		At Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 2, Box 329	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST										FIRST MIDDLE LAST			
Fred S. Elliott										Julia Elizabeth Lockhart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO.		17. INFORMANT	
No										236-72-0775		Walter McIntire Route 2, Box 329 Stephenson, VA 22656	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1890 IMMEDIATE CAUSE (a) <u>brain hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic ca</u> (c) <u>10 tumor - hypernephroma</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1980 - dx of hypernephroma			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
✓													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
March '80		hypernephroma				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8/11, 19 82, to 8/13, 19 82, that (I) (we) last saw the deceased alive on 8/13, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Nancy A. Hadley, M.D.										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy A. Hadley										22e. ADDRESS 612 Warner St. Baltimore, Md. 21230			
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		Aug. 17, 1982		Mt. Olive Cemetery		Hayfield Frederick Va.							
24. FUNERAL DIRECTOR NAME Omps Funeral Home										24a. PLACE REC'D. BY REGISTRAR AUG 19 1982		24b. REGISTRAR'S SIGNATURE John J. Connel	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar for death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 20674 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>BEATRICE W. McLAUGHLIN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>8 10 82</b>		2b. HOUR <b>3:15 PM</b>			
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 09 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALT. CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALT. CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL OF BALTIMORE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) STATE <b>MD</b>		13b. COUNTY <b>BALT CITY</b>		13c. CITY OR TOWN <b>BALT</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3327 MONDAWMIN AVE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>- - -</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>- - -</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219 30 9467</b>		17. INFORMANT ADDRESS <b>Boast McLaughlin 3327 Mondawmin</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART STOPPED</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>IDIOVENTRICULAR RHYTHM</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>ATHEROSCLEROTIC CORONARY VASCULAR DISEASE YEARS</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTES</b> <b>35 MINUTES</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>7/26/82</b> 19____, to <b>8/10/82</b> 19____, that (I) (we) last saw the deceased alive on <b>8/10/82</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Andrew V. Panagos MD</b>				DEGREE <b>RESIDENT PHYSICIAN</b>		22c. DATE SIGNED <b>8/10/82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREW V. PANAGOS</b>				22e. ADDRESS <b>SINAI REHABILITATION MEDICINE DEPT.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>md. Nat'l mem Ar.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel MD</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>					



BP\_\_\_\_\_

DHMH - 17

(VR A15 ME (5))

20M 4/B2

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John</b>		FIRST <b>Gary</b>		MIDDLE <b>Mc Laurin</b>		LAST		20. DATE KNOWN OF DEATH xx MONTH DAY YEAR 8 5 19 82		2b. HOUR	
3. SEX <b>M</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR 6 5 34		6. AGE (IN YEARS) (LAST BIRTHDAY) 48 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Port News</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 5 19 82		2d. HOUR 9:20	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital STU</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) <b>House Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>City of Balto</b>		13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>	
14. FATHER'S NAME FIRST LAST <b>Lawrence Mc Laurin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alberga Cox</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>223 38 6740</b>		17. INFORMANT ADDRESS <b>1302 Homestead St</b> <b>Theresa Mc Laurin</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of the cervical spine with complications</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).	
19a. DATE OF OPERATION <b>8/10/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>driver auto/fixed object/overtaken</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>6:20PM 7/8/82</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6:20PM 7/8/82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver auto/fixed object/overtaken</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>roadway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt301/NQueenAnneRd, Bowie, Prince George Co., MD</b>		22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER	
ACTUAL SIGNATURE <b>H. Guard</b>		EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>		ADDRESS <b>111 Penn Street, Balto., MD 21201</b>		DATE SIGNED <b>8/6/82</b>		23a. BURIAL, CREMATION, REMOVAL (BY C.F.P.) <b>Burial</b>		23b. DATE <b>8-10-82</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Marshall P. Hayes 638 N. Gilman St</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 09 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD 21225</b>			





Released as Non-Med By Dr Guard

Per Mr Freeman

DMMH-1650M/181  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked as item 18, report any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 0 6 7 6 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Neal McLean</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>08/21/82</b>		2b. HOUR <b>3:28P</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 12 24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John Hopkins Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph McLean</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty Leach</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>240-22-8613</b>		17. INFORMANT <b>Louvenia McLean</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4939</b> IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>asthma.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (EXPLAIN NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 21</b> , 19 <b>82</b> , to <b>AUG 21</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Justin C. McArthur</b>				DEGREE <b>MBBS</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/24/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>McARTHUR JUSTIN C.</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8/26/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

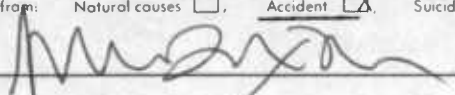
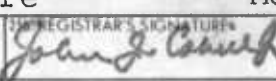
EX-22 ORD 2

EX-22 ORD 2

EX-22 ORD 2

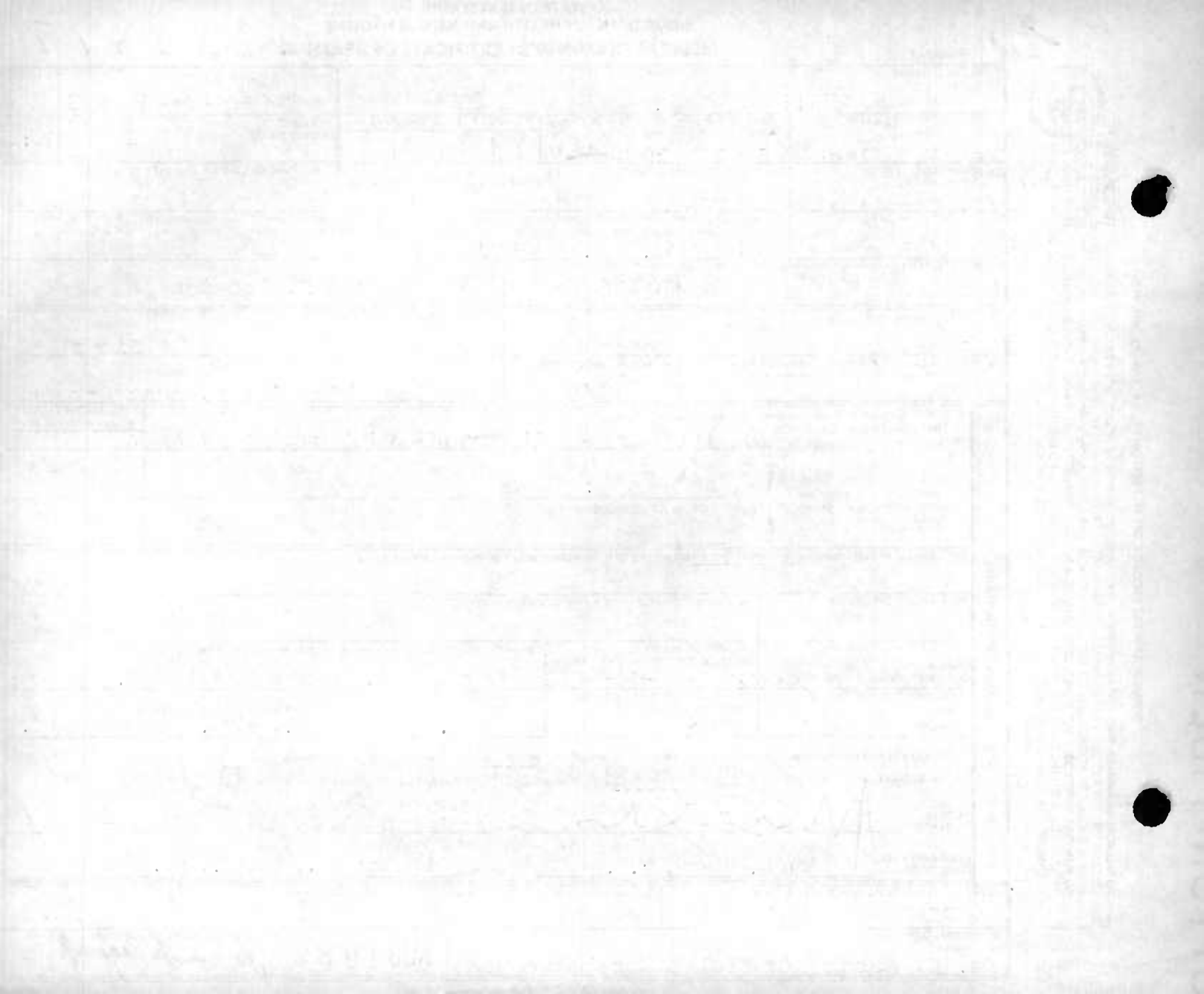
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20677

1. DECEASED NAME (TYPE OR PRINT)			FIRST NETTIE			MIDDLE B.			LAST MC LEAN			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 8			DAY 17			YEAR 1982			2b. HOUR M		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 26 20		6. AGE (IN YEARS) (DATE OF BIRTH) 68 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 17 1982			24 HOUR 10:27 P M											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.														
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. Gen. Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY										
13a. STATE Maryland												13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 740 N. Dension St.								
14. FATHER'S NAME FIRST MIDDLE LAST Joe McDowell						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosetta Simms																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A				17. INFORMANT ADDRESS Rosa Lee White 501 N. Mount Street																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism complicating fracture of femur</u> 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.																										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 1.30 P.M. 8-14-1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver in auto/fixed object impact.																		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1300 blk. Hilton Pkwy., Balto. Md.																		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																										
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 8-18-82												
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8/24/82				23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.														
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue												25a. DATE REC'D. BY REGISTRAR AUG 19 1982						25b. REGISTRAR'S SIGNATURE 								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 7 8  
REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH Charles McMANUS</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>82</b>		2b. HOUR <b>9:35 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>31</b> YEAR <b>1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER BALTO. MD 21218</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U S Postal Employee</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Govern.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Catonsville</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>21 C Montrose Manor</b>					
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b></b> LAST <b>McManus</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b> (IF YES, GIVE WAR OR DATES) <b>WW 1</b>		16b. SOCIAL SECURITY NO. <b>017 28 3725</b>		17. INFORMANT ADDRESS <b>Dorothy L. Smith, 1617 Park Grove Ave. 21228</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: <b>4960</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Chronic Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  
**Possible prostatic Carcinoma**

19a. DATE OF OPERATION <b>August 8</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>P.M.</b>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>	

22a. I certify that ☒ (this hospital) attended the deceased from **August 8**, 19 **82**, to **August 10**, 19 **82**, that ☒ (we) last saw the deceased alive on **August 10**, 19 **82**, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (and) (do not) view the body after death.

22b. SIGNATURE <b>R. OLIVO MD</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b></b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. OLIVO MD</b>		22e. ADDRESS <b>3900 Loch Raven Blvd. Balto. Md 21218</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8/13/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem</b>	23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b></b>
24. FUNERAL DIRECTOR NAME <b>1630 Edmondson Ave. Catonsville, Md</b> ADDRESS <b>Witzke Catonsville Funeral Home, P.A. 21228</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1982</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Casier</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

0-22:00 15:00-15:30



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 7 9  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Laskisha (Boyd) BABY GIRL McMorris			2a. DATE OF DEATH MONTH DAY YEAR 8-26-82			2b. HOUR 10:50 AM					
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR 6-23-82		6 AGE (IN YEARS LAST BIRTHDAY) YRS 2		IF UNDER 1 YEAR MONTHS 2 DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3029 Woodland Avenue		
14 FATHER'S NAME FIRST MIDDLE LAST Twyman			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Karen Boyd								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17 INFORMANT ADDRESS Karen Boyd 3029 Woodland Avenue					

11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7622 IMMEDIATE CAUSE (a) PULMONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) IMMATURITY DUE TO, OR AS A CONSEQUENCE OF (c) PREMATURE BIRTH.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James E. Taylor		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. TAYLOR				22e. ADDRESS ST AGNES HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/1/82		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk., Baltimore		23d. LOCATION CITY OR TOWN COUNTY STATE Md.	
24 FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR SEP-2-1982			
				25b. REGISTRAR'S SIGNATURE John J. Conner			



1/2

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STANFORD UNIVERSITY



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8220680	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> CARROLL <sup>MIDDLE</sup> MALACHI <sup>LAST</sup> McQUAY					2a. DATE OF DEATH MONTH DAY YEAR 8/12/82			2b. HOUR 11 <sup>25</sup> P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12-16-1927		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GUARD		12b. KIND OF BUSINESS OR INDUSTRY PENAL			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY N/A		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 413 ILCHESTER AVE. 21218			
14. FATHER'S NAME <sup>FIRST</sup> CARROLL <sup>MIDDLE</sup> M. <sup>LAST</sup> McQUAY SR.					15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> DOROTHY <sup>MIDDLE</sup> RICHARDSON <sup>LAST</sup>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II 220.20.1645		17. INFORMANT ADDRESS LOUISE R. McQUAY (same as 13e)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4149</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from Aug 9 19 82, to Aug 9 19 82, that (1) (we) last saw the deceased alive on above, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Warren M. Ross					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/13/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WARREN M. ROSS					22e. ADDRESS 3900 N. Chale St. Suite 104 Balt Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 8/14/1982		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY, MD.			
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. ADDRESS 21222					25a. DATE REC'D. BY REGISTRAR AUG 17 1982		25b. REGISTRAR'S SIGNATURE John J. Connel				

8-10-1918

8/10/18

10/10/18

10/10/18

RECEIVED



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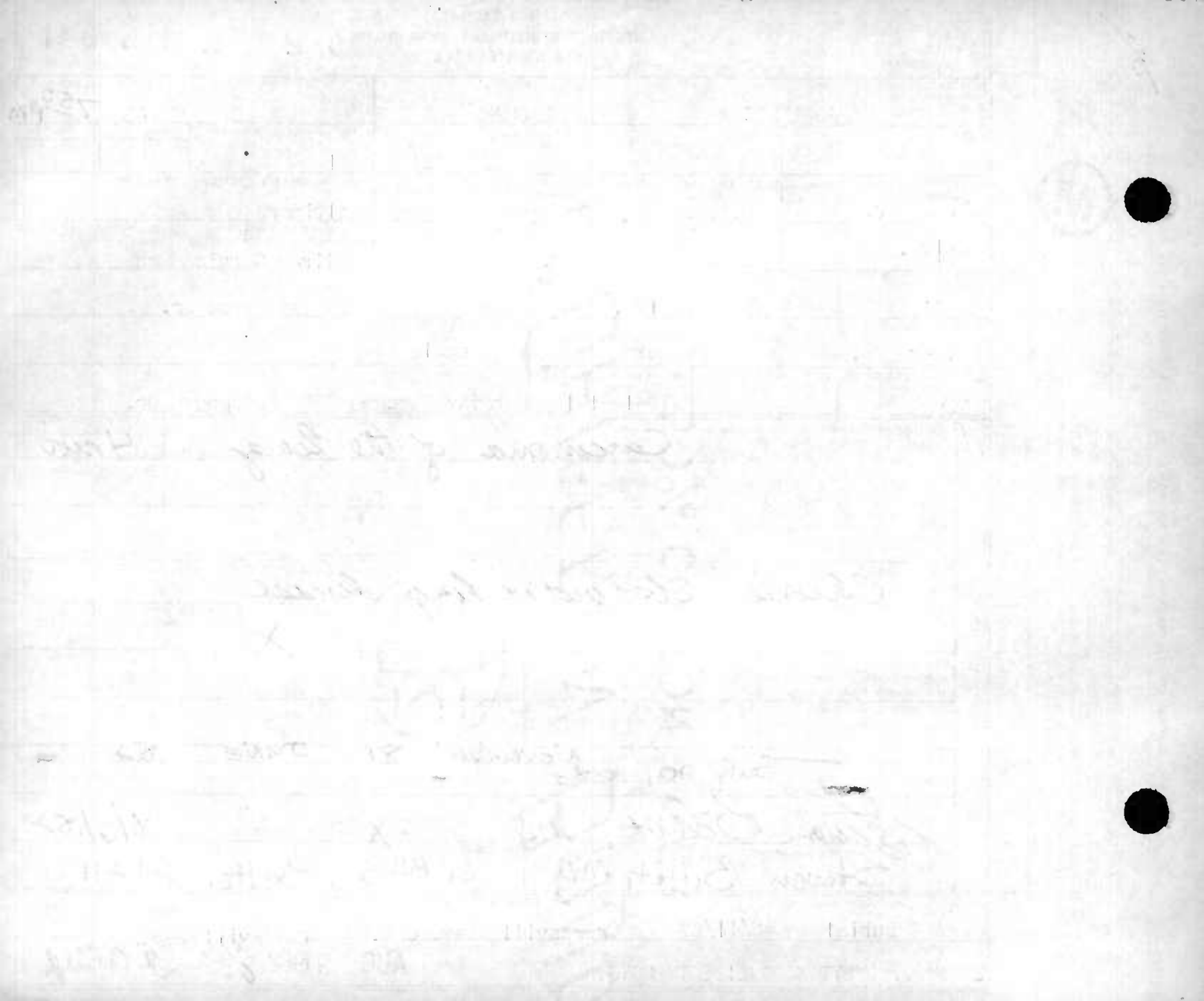
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 8 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ADOLPHUS MEACHAM			2a. DATE OF DEATH MONTH DAY YEAR 8 5 82		2b. HOUR 7:50 PM
3 SEX MALE	4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 4 25 21	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Car.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2626 Gatehouse Dr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Service Man		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Walter P. Meacham			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-18-1219	17. INFORMANT ADDRESS Dorothy Meacham 2626 Gatehouse Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. 1629 IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive lung disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) the hospital attended the deceased from November 19 81, to JUNE 19 82, that (I) lost saw the deceased alive on July 20, 19 82, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death.					
22b. SIGNATURE Steven Billet, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/6/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Billet, MD		22e. ADDRESS WPHS, Balto. 21211			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 8/11/82	23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md.	
24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HGTS.		ADDRESS AUG 9 1982		25a. DATE REC'D. BY REGISTRAR (OR REGISTRAR'S SIGNATURE) John J. Conner	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>JUANITA BELLE MEALEY</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 19, 1982</b>		2b. HOUR P <b>11:50 M</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11/22/1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4720 AMBERLY AVENUE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESPERSON</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4720 AMBERLY AVENUE 21229</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LLOYD DARLEY EDMOND</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCY HUNT</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>232.38.6428</b>		17. INFORMANT ADDRESS <b>ROBERT H. MEALEY (HUSBAND) (SAME AS 13e)</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1919</b> IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>progressive neurologic dysfunction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>glioblastoma multiforme recurrent</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION <b>11-19-81</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>brain tumor</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>Nov 16</b> 19 <b>81</b> , to <b>aug 19</b> 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>June 1</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did, and did not view the body after death.									
22b. SIGNATURE <b>Thomas B. Ducker</b> DEGREE						22c. DATE SIGNED <b>8-20-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas B. Ducker M.D.</b>						22e. ADDRESS <b>Univ of MD Hospital 22 S. Greene St</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>8/2/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		
24. FUNERAL DIRECTOR <b>WALTER BROOKS BRADLEY INC. BALTO., MD. 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 20683	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas C. Medinger										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 22 1982	2b. HOUR AM
3. SEX Male	4. RACE cauc	5. DATE OF BIRTH MONTH DAY YEAR 1/10/46	6. AGE (IN YEARS) LAST BIRTHDAY 36 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 8 22 19 82	7d. HOUR 9:10				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2201 Gough Street				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Sunpaper			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 5115 Meridy Ave. 21236							
14. FATHER'S NAME FIRST MIDDLE LAST Cornelius Medinger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Abt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 214-46-8100		17. INFORMANT ADDRESS Dale Medinger 5115 Meridy Ave						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3030 IMMEDIATE CAUSE (a) <u>Chronic alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>H R Guard</i>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER		DATE SIGNED 8/22/82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Balto. MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/25/82		23c. NAME OF CEMETERY OR CREMATORY Moreland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County				
24. FUNERAL DIRECTOR Scalimnek Funeral Home Inc. 3331 Brehms Lane Balto., Md. 21213					25a. DATE REC'D. BY REGISTRAR AUG 24 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>				

U.S. AIR FORCE

OFFICE OF THE SECRETARY OF THE AIR FORCE

WASHINGTON, D.C. 20330

TO: [illegible] FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

REFERENCE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

RECEIVED

NOV 17 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 8 4

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOURS MIN	
Victoria Dorothy MEEKINS		August 19, 1982		7:30a	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	72	MONTHS DAYS HOURS MIN	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore, Md.	U.S.A.		Baltimore City MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Maryland General Hospital		Housewife		At Home
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	734 S. Oldham Street 21224	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Frederick Palewick		Antonina Stemska			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-22-5074		Albert Palewick 312 S. Drew Street 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					10 months
IMMEDIATE CAUSE (a) Metastatic Oat cell Carcinoma					
1629 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Aspiration					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 11, 1982, to August 19, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on August 19, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Richard H. Lane		MD		8/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Richard Lane, M.D.		c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8-23-82		Sacred Heart Cem.	
24. FUNERAL DIRECTOR		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D BY REGISTRAR	
C.S. Zeiler & Son Inc. 6224 Eastern Avenue		Dundalk, Balt Co. Md.		AUG 20 1982	
23f. NAME ADDRESS		23g. SIGNATURE			
		John J. Conish			

1. Name of the person 2. Address 3. City 4. State 5. Zip		6. Date of birth 7. Sex 8. Race 9. Religion 10. Education		11. Occupation 12. Income 13. Assets 14. Liabilities 15. Other	
16. Signature 17. Date		18. Signature 19. Date		20. Signature 21. Date	

70



NOT

2-2-70 10:00 AM

FOR  
1 - STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 8 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN M. MENZIES</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>16</b> YEAR <b>82</b> 2b. HOUR <b>6 A.</b> M		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>October</b> DAY <b>24</b> YEAR <b>1894</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD		
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>T</b> LAST <b>Tarman</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Jane</b> LAST <b>Wyman</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-07-1476</b>	17. INFORMANT <b>Miss Dorothy M Menzies</b>		ADDRESS <b>Same</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROGRESSIVE RESPIRATORY FAILURE</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>adeno carcinoma of colon</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR (A.M. MONTH DAY YEAR) <b>6 P.M. 8 17 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/16/82</b> , 19 <b>82</b> , to <b>8/17</b> , 19 <b>82</b> , that (I) <b>we</b> last saw the deceased alive on <b>8/16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <b>we</b> did (did not) view the body after death.					
22b. SIGNATURE <b>Irving S. Gottfried</b>				22c. DATE SIGNED <b>8/16/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IRVING S. GOTTRIED MD</b>				22e. ADDRESS <b>201 EAST UNIVERSITY PARKWAY</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/19/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 18 1982</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 does any injury, or other traumatic event, the medical examiner must be notified at once.

12

12

12

12



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 8 6

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN E. Meseraceo</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-1-82</b>			2b. HOUR <b>5:25 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-23-14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>68</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>THE GOOD SAMARITAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Assembley, Westinghouse</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Glen Burnie</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>116 A Governors Court</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Julian ----- Bryant</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hester ----- Davis</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>220-14-9617</b>			17. INFORMANT ADDRESS <b>Mr. Thomas C. Meseraceo, Same as above</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4360 IMMEDIATE CAUSE (a) Aspiration</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Left Hemiparesis with Right Paralysis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-27</b> , 19 <b>82</b> , to <b>8-1</b> , 19 <b>82</b> ; that (I) (we) last saw the deceased alive on <b>8-1</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Sireesh Tripuraveni</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/1/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SIREESH TRIPURAVENI</b>						22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 4, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Rd. Howard Co, Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>McCutty Funeral Home, 237 E. Patapsco Ave. Balto. Md. 21225</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG - 3 1982</b>			
25b. REGISTRAR'S SIGNATURE <b>Frances Jean Warthen</b>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





WHITE

68

MILWAUKEE CITY

THE GOOD MORNING HOSPITAL

MILWAUKEE

110 & Governor Court

Blanchard

Milwaukee

220-14-2517

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Peter (Piotr) Paul Michocki</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 15, 1982</b>		2b. HOUR M <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 9, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Warsaw, Poland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4219 Sheldon Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Steelworker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Armco Steel Co.</b>
13a. STATE <b>Maryland</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4219 Sheldon Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Michocki</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophia Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-07-5157</b>		17. INFORMANT ADDRESS <b>Dennis J. Michocki 10101 Harford Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <b>1619 Respiratory Obstruction</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>Squamous Carcinoma of Larynx</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 19 1981</b> to <b>August 19 82</b> , that (I) (we) last saw the deceased alive on <b>Aug 6 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John F. Snow</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/16/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN F. SNOW</b>		22e. ADDRESS <b>University Hospital, Baltimore, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Aug. 17, 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>		ADDRESS <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1982</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 8 8

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Carolyn P. Miles</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-29-82</b>		2b. HOUR <b>12:19 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>07 09 45</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>37</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balto. General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>
13a. STATE <b>MD.</b>		13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Moses</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary.</b>		16. STREET ADDRESS <b>110 E Elizabeth Ave 21225</b>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		17b. SOCIAL SECURITY NO. <b>812-44-4615</b>		17c. FORMER ADDRESS <b>Baltimore - 110 Elizabeth Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>2559 IMMEDIATE CAUSE (a) Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Septic Shock.</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Adrenal suppression and Probable Ruptured appendix</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. <b>adrenal suppression</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8, 28 19 82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>19</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8, 28 19 82</b> to <b>8, 29 19 82</b> , that (I) (we) last saw the deceased alive on <b>8, 29 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Bryan S. Nolan M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8, 29, 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRYAN S. NOLAN</b>		22e. ADDRESS <b>South Balto. General Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>9/2/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>		23e. DATE REC'D. BY REGISTRAR <b>AUG 31 1982</b>			
24. FUNERAL DIRECTOR <b>Gurnell B. Oden</b>		ADDRESS <b>Balto. Md</b>		25. REGISTRAR'S SIGNATURE <b>John J. Canish</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Forms may be obtained from the Registrar.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 0 6 8 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>GWENDLYN FLORENCE MILES</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>AVG. 28 1982</b>		2b. HOUR <b>7:30 A</b>	
1. SEX <b>FEMALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AVG 14 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (IF FOREIGN, GIVE COUNTRY) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE, GIVE STREET ADDRESS) <b>3012 EVERGREEN AVE</b>		12a. USUAL OCCUPATION (USE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>—</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3012 EVERGREEN AVE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WLEN CHAS DETTMER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY LUELLA DEAN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>235-444804</b>		17. INFORMANT <b>DAUGHTER-LOUISE WHITE SAME</b>				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>3400 BRONCHITIS PNEUMONIA</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>MUSCULAR DYSTROPHY</b> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>AVG 26 19 82</b> to <b>AVG 28 19 82</b> , that (I) (we) lost saw the deceased alive on <b>AVG 26 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Donald W. Mintzer</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>AVG 28 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD W. MINTZER</b>		22e. ADDRESS <b>3009 EVERGREEN AVE BALTIMORE MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-2-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT UNION</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Monrovia W. VA.</b>	
24. FUNERAL DIRECTOR NAME <b>E BARNES</b>		ADDRESS <b>FLEMING FUNERAL SERVICE BENSON MD</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 31 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carney</b>	





WYA U.S.A. Baltimore City

1000 North 30th Street Baltimore Md 21201

Phone (410) 542-1234

Telex 123456789

Radio 123456789

Teletype 123456789

Mail 123456789

Post 123456789

Telegraph 123456789

Radio 123456789

Teletype 123456789

Mail 123456789

Post 123456789

Telegraph 123456789

Radio 123456789

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Post 123456789

Telegraph 123456789

Radio 123456789



item 7a 1G570 8/31/82 ph

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2

REG. NO. 20690

1. DECEASED NAME (TYPE OR PRINT)			FIRST James			MIDDLE Walter			LAST Miles Sr.			2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 8 8 19 82			2c. HOUR M 6:52 P.M.				
3. SEX Male		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 3/8/21		6. AGE (IN YEARS) (LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 8 19 82			2d. HOUR P.M.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY Longshoreman							
13a. STATE Md.				13b. COUNTY				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 3923 Maine Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Elliott Alexander						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Blanden													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW2				17. INFORMANT Zora Miles				17. ADDRESS 3923 Maine Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 8-9-82											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/12/82				23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md.							
24. FUNERAL DIRECTOR NAME Chas. A. Rice				ADDRESS FHPA 1300 Eutaw Pl.				25a. DATE REC'D. BY REGISTRAR AUG 17 1982				25b. REGISTRAR'S SIGNATURE John J. Conner							

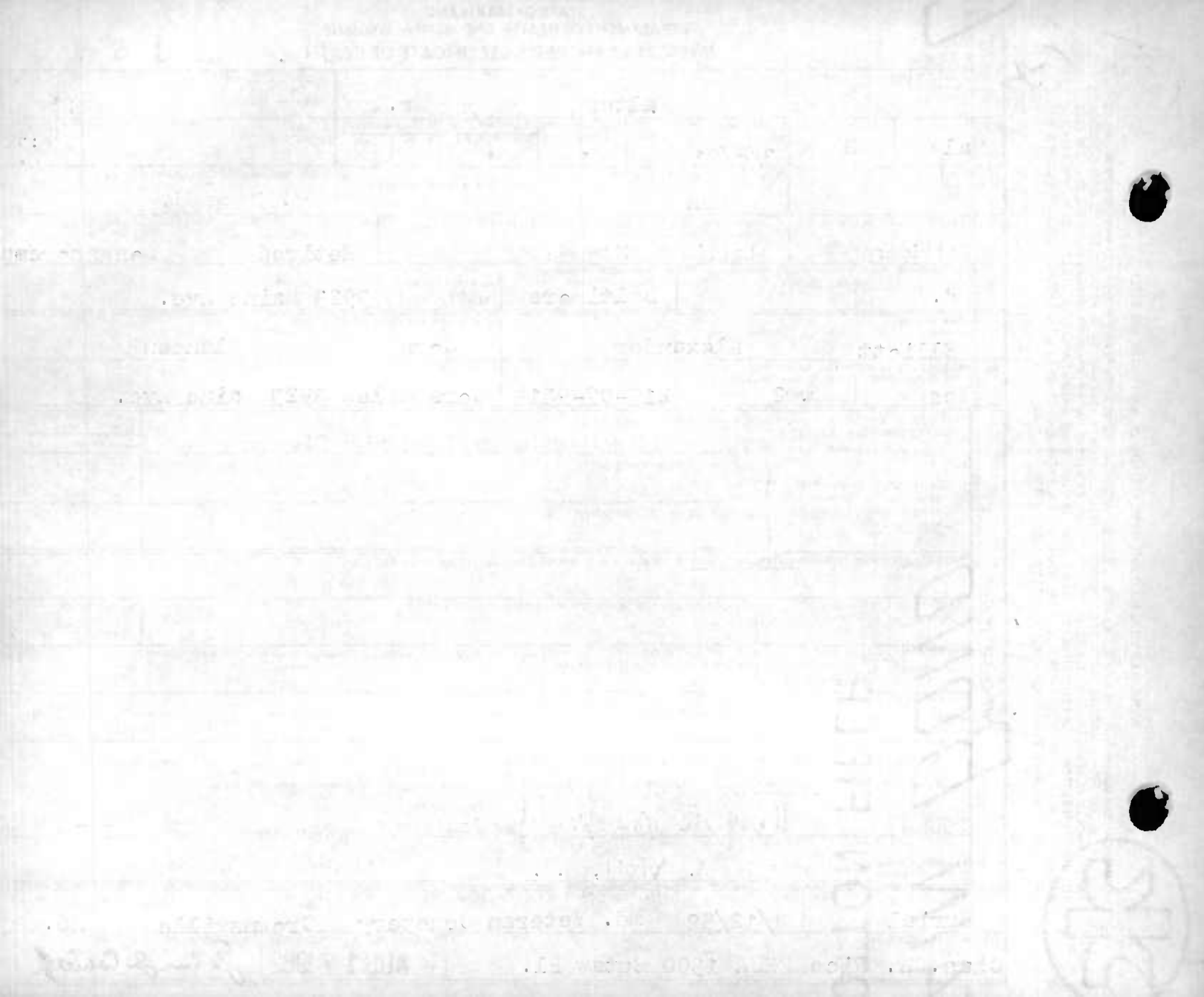
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 0 6 9 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EVELYN ANTONYA MILLARD</b>				20. DATE OF DEATH MONTH DAY YEAR 2b HOUR <b>8 8 82 10:10 P.M.</b>			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 12 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>76</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Yugoslavia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY <b>Utah</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>145 Est 200 North # 35</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>late Joseph Stimas</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Antonia</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>528 34 2878</b>		17. INFORMANT ADDRESS <b>Mr Bengt F Anderson 6165 Commander Ct. Columbia Md 21045</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4349</b> IMMEDIATE CAUSE (a) <b>Cerebral infarct, right</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral atherosclerosis + thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Secondary biliary cirrhosis - Bronchopneumonia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/23</b> , 19 <b>82</b> , to <b>8/8</b> , 19 <b>82</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>8/8</b> , 19 <b>82</b> , and that in (my <input checked="" type="checkbox"/> our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE <b>William D. Hicken MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/9/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.M. J. HICKEN, M.D.</b>				22e. ADDRESS <b>St Agnes Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug 12, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SALT Lake City Utah</b>	
24. FUNERAL DIRECTOR <b>Harry H Witzke</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1982</b>		25b. SIGNATURE OF REGISTRAR <b>John J. Conner</b>	

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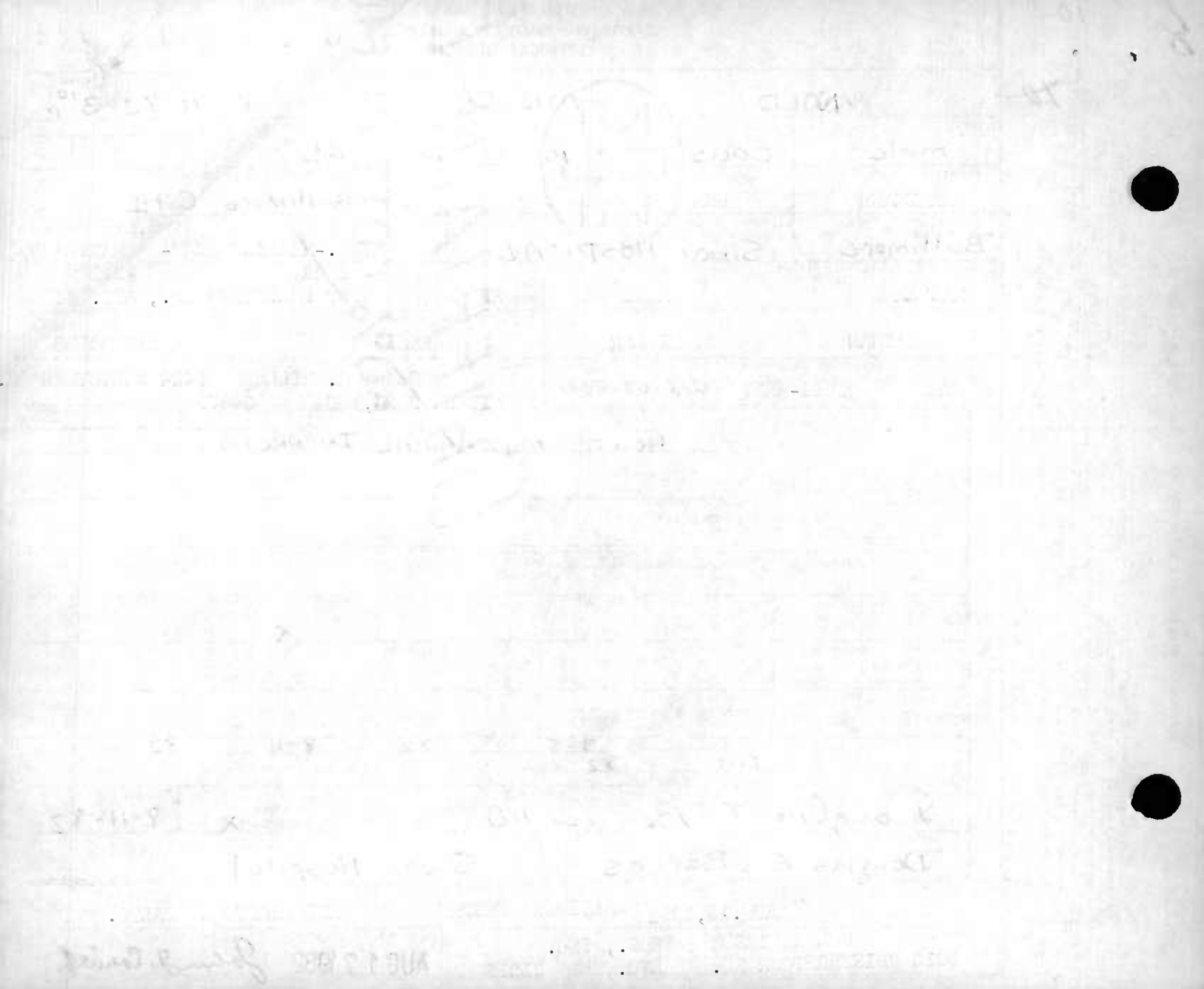
U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called about.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 2 0 6 9 2						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR		
1. DECEASED NAME FIRST MIDDLE LAST ARNOLD MILLER					8 11 82				3 <sup>10</sup> P M		
3. SEX male		4. RACE caus		5. DATE OF BIRTH MONTH DAY YEAR 10 12 16		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTY.-HEARING EXAM-		12b. STATE OF BUSINESS OR INDUSTRY MARYLAND			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS INNER #21209 2909 FALLSTAFF RD., APT. 41			
14. FATHER'S NAME FIRST MIDDLE LAST NATHAN MILLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE KOENIGSBERG							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII-ARMY 212-07-8091		17. INFORMANT ADDRESS ROBERT A. MILLER 9424 WHETSTONE DR. GAITHERSBURG, MD 20879					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-5, 19 82, to 8-11, 19 82, that (I) (we) lost saw the deceased alive on 8-11, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Douglas E. Barnes MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-11-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas E. Barnes						22e. ADDRESS Sinai Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUG. 13, 1982		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW			23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR AUG 17 1982		25b. REGISTRAR'S SIGNATURE Joan J. Carver			





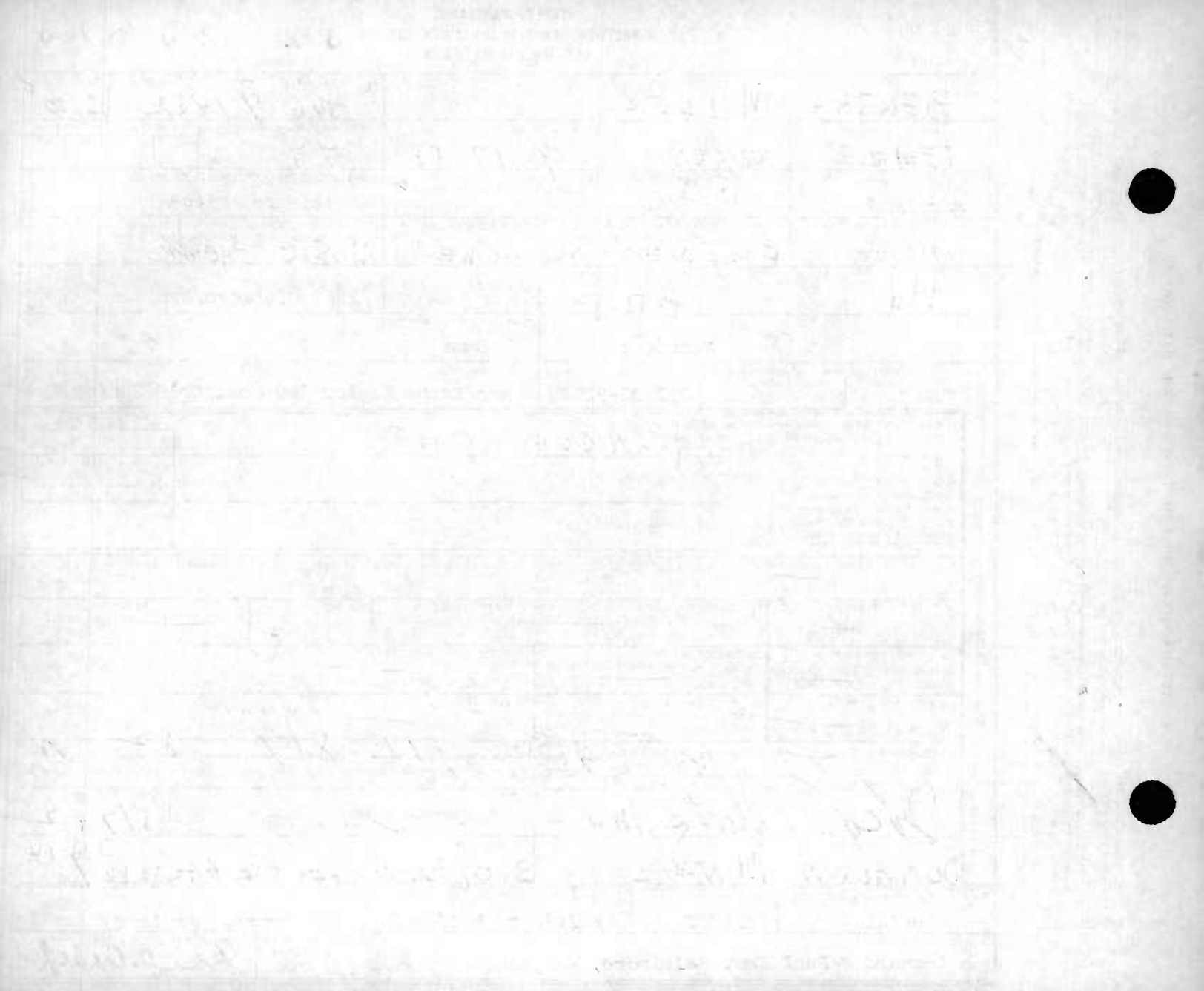
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 9 3

REG. NO.

1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA B. MILLER		2. DATE OF DEATH MONTH DAY YEAR AUG 7 1982		3. HOUR P 2:00 M	
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 17 88		6. AGE (IN YEARS LAST BIRTHDAY) 94	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EDGEWOOD NCL HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MUSIC TEACHER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md	13b. COUNTY	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2909 Glenmore Ave
14. FATHER'S NAME FIRST MIDDLE LAST ? Menniger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-32-9262		17. INFORMANT ADDRESS Mrs Irene Taylor 100 West Cold Spring La	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASACVD - CHF 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (LAB, HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/30 19 77 to 8/7 19 82 that (I) saw the deceased alive on 6/30 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald W. Minter M.D.		DEGREE		22c. DATE SIGNED 8/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD W. MINTER		22e. ADDRESS 3009 EVERGREEN FIVE BALTIMORE		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/11/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23d. FUNERAL DIRECTOR NAME Leonard J Rucit Inc. Baltimore, Maryland		23e. DATE REC'D. BY REGISTRAR AUG 10 1982		23f. REGISTRAR'S SIGNATURE John J. Casper	
23g. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					





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FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 9 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HILDA B. MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 20 1982</b>		2b. HOUR <b>3:10a</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 17 1910</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LOUISIANA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOME + HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>			13b. CITY OR TOWN <b>BALTO. PARKVILLE</b>	13c. STREET ADDRESS <b>8706 STOCKWELL ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN MATOSKA</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BARBARA LICH</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>230 14 7611</b>	17. INFORMANT ADDRESS <b>FAMILY</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) CARDIAC ARREST</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIOGENIC <del>SE</del> SHOCK</b>					
DUE TO, OR AS A CONSEQUENCE OF (c) <b>MYOCARDIAL <del>MYOCARDIAL</del> INFARCT</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES, UNSTABLE ANGINA</b>					
19a. DATE OF OPERATION <b>8-9-82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GASTRIC ULCER</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8-3</b> , 19 <b>82</b> , to <b>8-20</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8-20</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Walter Bender</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER BENDER</b>		22e. ADDRESS <b>CHURCH HOME HOSPITAL 100 N. BROADWAY BALTIMORE MD. 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM. BALTIMORE</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>EVA'S FUNERAL CHAPEL 8800 HARFORD RD</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 30 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gierck</b>	



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FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 6 9 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SAVANNAH MILLER			2a. DATE OF DEATH MONTH DAY YEAR 8-31-82		2b. HOUR 1:55 PM
3. SEX FEMALE	4. RACE COL ✓	5. DATE OF BIRTH MONTH DAY YEAR SEPT 23, 1899	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CLINTON N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. DEATON Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MARYLAND	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 3308 WINDSOR AVE	
14. FATHER'S NAME FIRST MIDDLE LAST MATTHEW GENE SAMPSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGGIE SAMPSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217 402889A		17. INFORMANT ADDRESS MRS PAULINE WILLIAMS 124 W. FRANKLIN ST	
18. CAUSE OF DEATH (Enter only one cause, and for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 5140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, list (b) <u>S/Prespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary edema</u> APPROXIMATE INTERVAL BETWEEN PART I AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (WEATHER, MOTOR MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, TRAM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 15</u> 19 <u>82</u> to <u>Aug 31</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>Aug 31</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Julian W. Reed M.P.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/1/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN W. REED		22e. ADDRESS 6115 CHAS. ST. BALTO. MD 21230			
23a. BURIAL, CREMATION, REMOVAL (BY) BURIAL		23b. DATE 9-4-82	23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM PK		23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS BALTO Co. MD
24. FUNERAL DIRECTOR NAME JOSEPH H. RUSSELL		ADDRESS 2227 W. NORTH AVE		25a. DATE REC'D. BY REGISTRAR SEP 7 1982	
				25b. REGISTRAR'S SIGNATURE John J. Corwin	

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows]

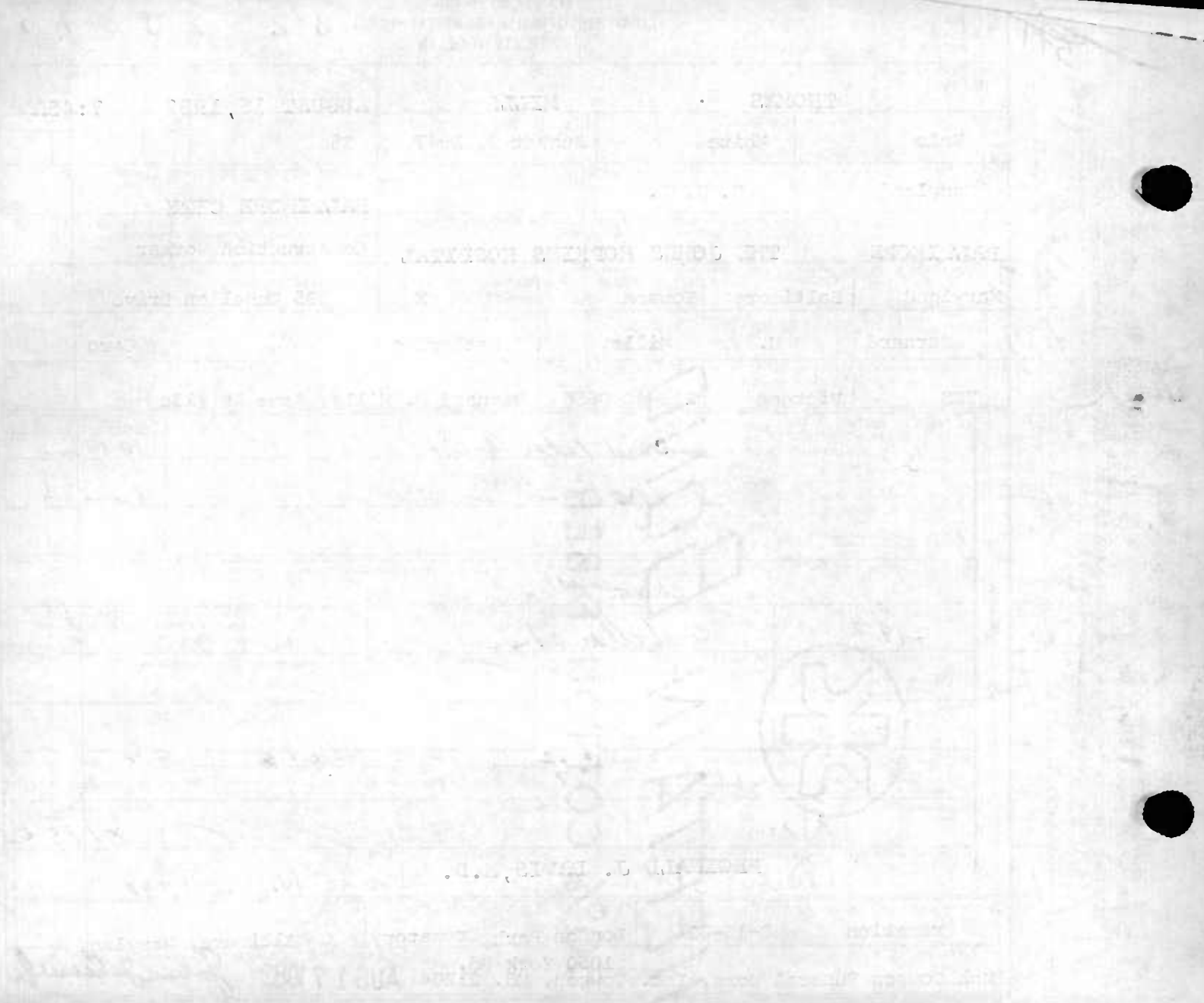
[Illegible text follows]

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 0 6 9 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS B. MILLS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 15, 1982</b>		2b. HOUR <b>7:45A M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 9, 1947</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>35</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard M. Mills</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Caro</b>		13e. STREET ADDRESS <b>935 Dunellen Drive</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Vietnam</b>		17. INFORMANT ADDRESS <b>Bernard M. Mills, Same As #13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>2399 IMMEDIATE CAUSE (a) Card Pector Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Past Tension Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-15 min</b> <b>1 month</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Illness</b>							
19a. DATE OF OPERATION <b>7/8/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cerebellar Abscess</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/9/82</b> , 19 <b>82</b> , to <b>8/15</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8/15</b> , 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>[Signature]</b>		22c. DATE SIGNED <b>8/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Davis</b>				22e. ADDRESS <b>REGINALD J. DAVIS, M.D. Johns Hopkins Hosp</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>8-16-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>C Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1982</b>			
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 0 6 9 7	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy M Mincey</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 31 82</i>		2b. HOUR MIN. <i>11 00</i>
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 9 35</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>45</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>city</i> MD.		
10. CITY OR TOWN OF DEATH <i>Blt</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Un P Md</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>	13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>2824 Harlem Ave</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Benjamin Jones</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Whitby De la Whitby</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-30-859</i>	17. INFORMANT ADDRESS <i>Maufice Stokes 2317 Sidney Ave</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> <i>1509</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>malnutrition</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ca. of esophagus</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <i>seizure disorder</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/24</i> , 19 <i>82</i> , to <i>8/31</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>8/31</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Wayne E. Guider MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>8-3-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wayne E. Guider MD</i>		22e. ADDRESS <i>Un P Md Hosp</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>9/4/82</i>	23c. NAME OF CEMETERY OR CREMATORY <i>King Mem PK</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md</i>	25a. DATE REC'D. BY REGISTRAR <i>SEP-2-1982</i>	
24. FUNERAL DIRECTOR NAME <i>Wm. C. March</i>		ADDRESS <i>Flt 1101 E. North Ave</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

Handwritten notes on lined paper, including a date stamp "JAN 19 1960" and a large "X" mark.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 2 2 0 6 9 8					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR					
Thomas C. Miskimon					August 25, 1982					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		
Male		White		10 22 09		72		430 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		U.S.A.				Baltimore City		Can Co.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		3019 Falt Avenue				Mechanic		Can Co.		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland							Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Philip Thomas Miskimon					Margaret Ritz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		16c. INFORMANT'S ADDRESS			
Yes					WW II		215-01-7823			
					Michael F. Kantorski, 805 Loalan Avenue, Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a)									Sudden Death	
DUE TO, OR AS A CONSEQUENCE OF										
(b) Ischemic Cardiomyopathy										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
			HOUR A.M. MONTH DAY YEAR							
			P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN STREET COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from March 19 80, to Aug 19 82, that (I) (we) last saw the deceased alive on 7/28 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (we) did not view the body after death.)										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
E. Miller MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			8/27/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
E. Miller MD					11 E. Chase St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial			8-28-82		Oak Lawn Cemetery		Baltimore Baltimore Md.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Nicholas T. Matthews, 3021 Eastern Avenue, Baltimore, Md.						AUG 31 1982		John J. Carver		

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100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

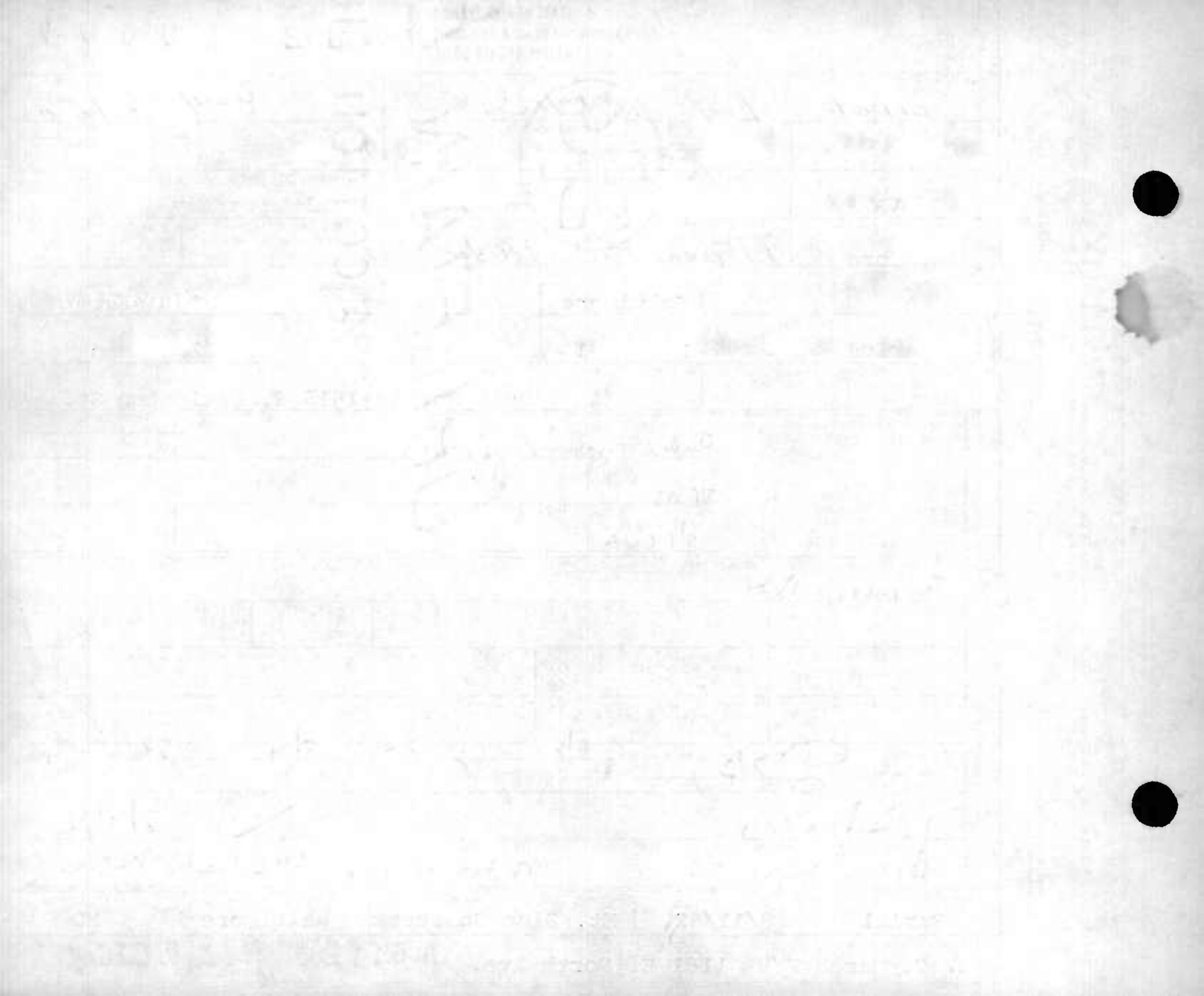
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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 2 2 0 6 9 9 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Ernest Lee Mitchell					2a. DATE OF DEATH MONTH DAY YEAR 8-4-82 2b. HOUR 12 <sup>20</sup> A.M.				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 5 24		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) J. L. Deafen Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2668 Kennedy Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Mitchell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Globeland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Ruth Morris 1815 N. Lexington St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic failure</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEMI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>SLCWA</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Seizures, DM</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/3</u> to <u>8/4</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Brian Bohannon</u>		22c. DATE SIGNED 8/4/82				22d. ADDRESS Deafen Medical Center 611 S. Charles, Balt, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/11/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.					25. DATE REC'D BY REGISTRAR AUG 11 1982				
26. REGISTRAR'S SIGNATURE <u>John J. Lander</u>									

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21g marked or item 18 shows any injury or other traumatic event, then medical examiner must be called for approval.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR		George A. F.		Mittell		8 2 2 0 7 0 0			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		Mittell		2a. DATE OF DEATH		MONTH DAY YEAR	
MITCHELL		GEORGE				8 17 82		2b. HOUR 808 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Male		White		MONTH DAY YEAR		78 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
England		U.S.A.				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Baltimore City Hospitals				Welding		Reed-Avery	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1725 Stokesley Road	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
George W. V. Mittell				Elizabeth Tanner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		212-30-0542		Eric Mitchell		1725 Stokesley Road Balto. MD 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									
2030 IMMEDIATE CAUSE (a) CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE MYELOMA									
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC SUBDURAL HEMATOMA									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) MULTIPLE MYELOMA, SUBDURAL HEMATOMA									
19a. DATE OF OPERATION		19b. OPERATION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
8/17/82		CHRONIC SUBDURAL HEMATOMA				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
		HOUR A.M. MONTH DAY YEAR		PATIENT FELL OUT OF BED		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		HOSPITAL		BALTIMORE CITY HOSPITAL		YES <input type="checkbox"/> NO <input type="checkbox"/>			
22a. I certify that (I) (this hospital) attended the deceased from 8/17 to 8/17, 1982, and that in (my) (our) opinion death occurred on the date and hour stated from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Charles W. Hottel		M.D.		8/12/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Charles Van Hout		BALTIMORE CITY HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation		8/18/82		Green Mount		CITY OR TOWN COUNTY STATE			
						Baltimore Maryland			
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME Duda-Ruck, Inc.		ADDRESS 7922 Wise Avenue, Dundalk, MD 21222		AUG 18 1982 John J. Carver					



14-15-50

14-15-50

14-15-50

14-15-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by doctor.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 0 7 0 1	
FOR 1 - STATE REGISTRAR										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLARA M. MIX						2a DATE OF DEATH MONTH DAY YEAR 8 / 23 / 82		2b HOUR 259 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 20 1885		6 AGE (IN YEARS LAST BIRTHDAY) 96 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant - Crown Cork & Seal Co.		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland						13b COUNTY Baltimore		13c CITY OR TOWN Baltimore			
14 FATHER'S NAME FIRST MIDDLE LAST John Mix						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Deigert					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-01-0272		17 INFORMANT ADDRESS Ruth Rozankowski 2908 Shirey Ave.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Resp Failure</u> <u>4280</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>END STAGE Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Acute Renal Failure, Uremia</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>8/22</u> 19 <u>82</u> to <u>8/23</u> 19 <u>82</u> that (I) (we) (ant saw the deceased alive on <u>8/22</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>David C. Allen MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 8/23/82					
22d PHYSICIAN'S NAME (TYPE OR PRINT) DAVID C. ALLEN				22e ADDRESS 201 E. UNIVERSITY PARKWAY 21218							
23a BURIAL, CREMATION, REMOVAL (Burial)		23b DATE Aug. 25, 1982		23c NAME OF CEMETERY OR CREMATORY Western Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland						25a DATE REC'D. BY REGISTRAR AUG 24 1982		25b REGISTRAR'S SIGNATURE <u>Thos. J. Carver</u>			

ASBURY UNIVERSITY

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

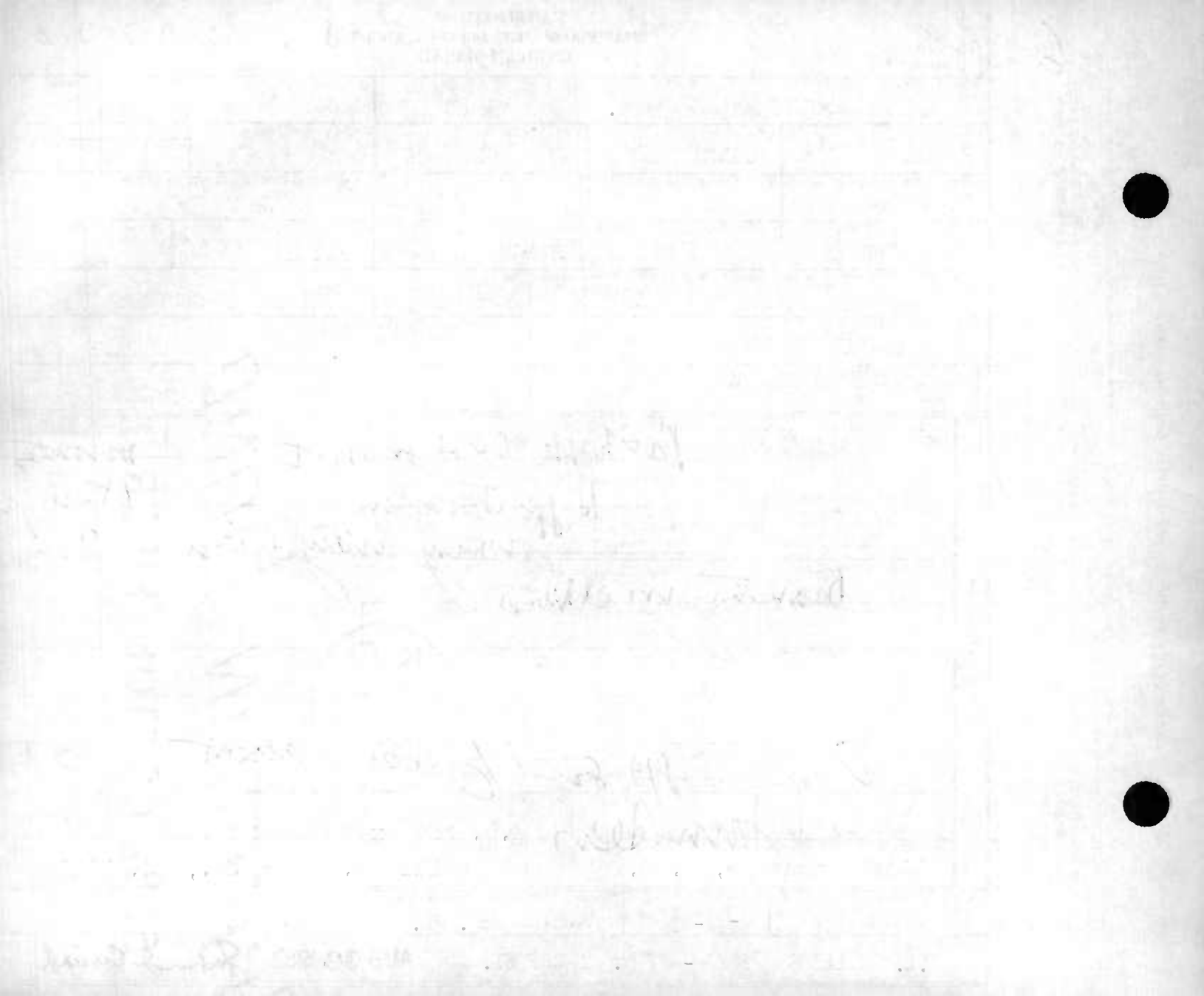
1 DECEASED NAME (TYPE OR PRINT) MATTIE L. MOODY			2a. DATE OF DEATH MONTH DAY YEAR 8 26 82			2b. HOUR M			
3 SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 9 21 06		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) ALABAMA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2539 LOYOLA SOUTHWAY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND			13c. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2539 LOYOLA SOUTHWAY		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLIE COLBERT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS BETTIE REED 2539 LOYOLA SOUTHWAY				
18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4100 Probable CVA or M.I.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>15-20 yrs</u> <u>ri</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>1/6/66</u> to <u>present</u> 19 <u>82</u> , that (I have) last saw the deceased alive on <u>1/6/82</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.									
22a. SIGNATURE <u>Elijah Saunders</u> DEGREE M.D.						22b. DATE SIGNED 8/30/82		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elijah Saunders, M. D.						22e. ADDRESS 2 Hamill Rd. Balto., Md. 21210			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-31-82		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS 1721 - 27 <sup>th</sup> N. MONROE ST.						25a. DATE REC'D. BY REGISTRAR AUG 30 1982			
						25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

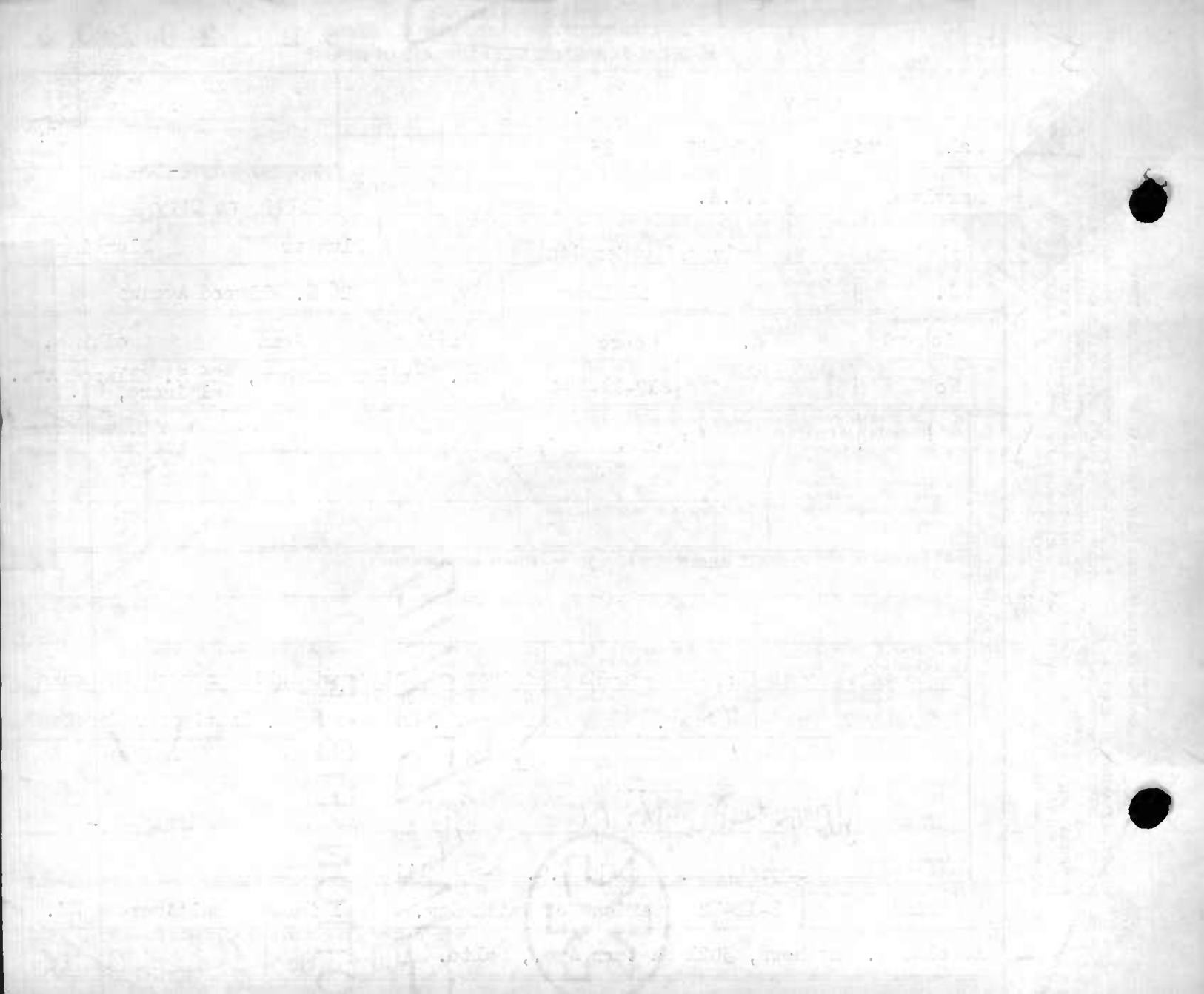
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department's office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 2 0 7 0 3	
1. DECEASED NAME (TYPE OR PRINT) <b>LARRY R. MOORE</b>						2a. DATE KNOWN OF DEATH <b>8-10-82</b>		2b. HOUR <b>1:04A</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>4-28-57</b>	6. AGE (IN YEARS) <b>25</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>8-10-82</b>		7d. HOUR <b>1:04A</b>			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		9d. HOUR <b>1:04A</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plumber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>			
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS <b>526 S. Ellwood Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard A. Moore</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marilyn Jean Bodkin</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-14-4494</b>		17. INFORMANT ADDRESS <b>Mrs. Marilyn Barbera, 526 S. Ellwood Ave. Baltimore, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12:08AM 8-10-82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>driver of motorcycle which struck the rear of tractor trailer</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>hwy.</b>		21f. STREET CITY OR TOWN COUNTY STATE <b>6700 blk. Pulaski Hwy. Baltimore, Maryland</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>8-10-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-12-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Md.</b>				
24. FUNERAL DIRECTOR <b>Nicholas T. Matthews, 3021 Eastern Ave., Balto.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1982</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the death information with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 20704 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alice Moorman</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8-20-82</b>			2b. HOUR <b>M</b>		
3. SEX <b>F</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-6-08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD					
10. CITY OR TOWN OF DEATH <b>Balto</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1810 Dukeland St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md</b>		13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1810 Dukeland St</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Blackwell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lydia BRANFORD</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Lydia Lee</b>				ADDRESS <b>1810 Dukeland St</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction -</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden - minute</b> <b>1965</b> <b>1958</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>23 Sept</b> , 19 <b>65</b> , to <b>20 Aug</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>10 Aug</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles R. Davidson</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>21 Aug 82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles R. Davidson, M.D.</b>				22e. ADDRESS <b>2034 W. North Ave Baltimore, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/26/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto Md</b>			
24. FUNERAL DIRECTOR NAME <b>Vernon R. Bailey</b>				ADDRESS <b>1318 N. Calhoun St.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 24 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			

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COAST GUARD

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WADE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 0 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WADE MORAGNE-EL		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 17, 1982		2b. HOUR 8:05 PM
3. SEX M	4. RACE B I K	5. DATE OF BIRTH MONTH DAY YEAR 6 - 15 - 00		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
13a. STATE Md		13b. COUNTY	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WADE MORAGNE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLLIE JENNINGS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS WADE MORAGNE-EL 815 N. GILMORE ST.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable sepsis 4860 DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Renal Failure				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 8/14, 19 82, to 8/17, 19 82, that (I) (we) last saw the deceased alive on 8/17, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Drew Pardoll		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/17/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Drew Pardoll		22e. ADDRESS Johns Hopkins Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/21/82	23c. NAME OF CEMETERY OR CREMATORY Ring Men. Pl.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Vernon E. Bailey		25a. DATE REC'D. BY REGISTRAR AUG 24 1982		25b. REGISTRAR'S SIGNATURE John J. Canine

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WASHINGTON CITY

JOHN W. HARRIS

WASHINGTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 2 0 7 0 6									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Norman		F.		Moran				August 19, 1982		445 P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
male		white		June 5, 1893		89					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Charles Co. Md.		USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Long Green Nursing Home						retired broker		insurance	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Baltimore		Towson				204 E. Joppa Road			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John Marshall Moran		Eva Rice									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
Yes		WWI		215-32-8604A		N.Clark Moran 8011 Strauff Rd. Bal.Md. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CANCER OF COLON WITH LUNG METASTASIS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS</u>	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1539</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>81</u> , to <u>AUGUST 19</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8-17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Miguel Karacuschansky</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>8-20-82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
MIGUEL KARACUSCHANSKY M.D.		300 E. 33rd St BALTO Md 21218									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Aug. 23, 1982		Loudon Park Cem.		Baltimore Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							
Mitchell-Wiedefeld Home		6500 York Rd. Bal. Md.		AUG 25 1982 <u>[Signature]</u>							





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 0 7 0 7			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
KENNETH LYTTLETON MORGAN				8/23/82			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		White		MONTH DAY YEAR		68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				BALT CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO		Good Samaritan		Analyst - Financial		B&O RR	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland						Baltimore	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Lyttleton Mordecai Morgan				Delia Florence Dalrymple			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
Yes Army				212 01 0930		Mrs. Margaret Morgan, Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Probable acute myocardial infarction							
DUE TO, OR AS A CONSEQUENCE OF (b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
Hypertension, Nephrotic syndrome, Obesity							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
-		-		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 8-23, 1982, to 8-23, 1982, that (he/we) lost saw the deceased alive on 19, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did/did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Antonio S. Cassavego MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		8-23-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Antonio S. Cassavego				5601 LOCH RAVEN BLVD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		8/26/82		Parkwood Cemetery		Balto. County, MD.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212				AUG 24 1982		John J. Connel	





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 20 / 08 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>Morrison Morgan</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8 27 82</b>			
3. SEX <b>Male</b>				7b. HOUR <b>M</b>			
4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 21 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>814 / Bethune Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>814 Bethune Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Morgan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriet Kess</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>219-05-5352</b>		17. INFORMANT ADDRESS <b>Mabel L. Morgan 814 Bethune Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4960</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Chronic Obstructive Pulm. Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE <b>Dr. E. V. Cyriac</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/27/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. E. V. CYRIAC</b>				22e. ADDRESS <b>7445-A FURNACE BR.-RD CROWN BURNIE MD 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/1/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownville Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 31 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canick</b>	



Handwritten text, possibly a signature or date, located in the center of the page. The text is faint and difficult to decipher.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 0 7 0 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ETHEL MORRISON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8 18 82</b>			
3. SEX <b>Female</b>				2b. HOUR <b>11:15 AM</b>			
4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 10 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>60 YRS.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>1725 N. Bond St</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. STREET ADDRESS <b>1725 N. Bond St</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lucious Vance</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Luxenia Crosby</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>149-18-9488</b>		17. INFORMANT <b>Rev. Robby Morrison</b>		ADDRESS <b>1725 N. Bond St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Brain metastasis</b> (c) <b>Ca. of Lung</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 10</b> 19 <b>82</b> to <b>Aug. 18</b> 19 <b>82</b> , that (I) (we) lost <b>above</b> , (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Rondato L. Borja</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/18/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HONRATO L. BORJA MD</b>		22e. ADDRESS <b>C/O GOOD SAMARITAN HOSP.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-23-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore City</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME <b>Randolph J. Collick</b>		ADDRESS <b>2431 E. Oliver St.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 20 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8220710	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Marjorie D. MORRISON</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>August 12, 1982</b>			2b. HOUR <b>10:35<sup>am</sup></b>		
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 15 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Law firm</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1027 Cathedral St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Morrison</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fairchild</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>723-09-0833</b>		17. INFORMANT ADDRESS <b>Mr. Howard Smith Westminster, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma involving pelvis with nodules of tumor surrounding large bowel and bladder</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>1953</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Old Myocardial Infarction with congestive heart failure</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 23</b> , 19 <b>82</b> , to <b>August 12</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>August 12</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <b>Richard A. Lane</b> MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>8/12/82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard A. Lane, M.D.</b>						22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>8/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			



RECEIVED  
JUL 17 1968  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.



On August 12, 1968, the following information was received from the Bureau of the Federal Bureau of Investigation:

Information was received from the Bureau of the Federal Bureau of Investigation that on August 12, 1968, the following information was received from the Bureau of the Federal Bureau of Investigation:

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IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be called to the scene.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 0 7 1 1 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Jack Moses</b>				2b. HOUR <b>M</b>			
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 24 22</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>60</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1116 E. 20th St.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1116 E. 20th St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Phillip Moses</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabelle Gibson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>248-26-1192</b>		17. INFORMANT ADDRESS <b>Beatrice Moses 1116 E. 20th St.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4110</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Hypertensive C V Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1968</b> , 19____, to <b>8/9/82</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/1/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Borofsky MD</b> DEGREE				22c. DATE SIGNED <b>8/10/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S BOROFSKY</b>				22e. ADDRESS <b>4734 Park Heights 21215</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Sam E. Canick</b>	

11.05.2020

1. The first part of the report is a general introduction to the project. It describes the objectives of the study and the methods used to collect data. The second part of the report is a detailed description of the results of the study. It includes a table of the data collected and a discussion of the findings. The third part of the report is a conclusion and a list of references.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 0 7 1 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>NAOMI L MOSLEY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 04, 1982</b>		2b. HOUR <b>06:42AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 21 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81 YRS.</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John H. Mosley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Patterson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Dorothy L. Ross 1223 N. Broadway</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Artery Stroke</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Possible Septic</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Day 1</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ( )							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>7/21</b> , 19 <b>82</b> , to <b>8/4</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8/4</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.	
22b. SIGNATURE <b>Barbara Little</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/4/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Barbara Little</b>		22e. ADDRESS <b>Dept of Medicine, Johns Hopkins Hspt</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8/7/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 06 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 2 2 0 7 1 3				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Doris Eleanor <del>Moulton</del> Moulton					2a. DATE OF DEATH MONTH DAY YEAR 8 10 82 2b. HOUR 7:45 AM				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11 8 15		6. AGE (IN YEARS LAST BIRTHDAY) 66		7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN Baltimore 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET ADDRESS 2324 N. Charles Street				
14. FATHER'S NAME FIRST MIDDLE LAST John McHale Burns					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie May Hughes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-24-3975		17. INFORMANT ADDRESS Havre de Grace, Md. Mrs. Elizabeth B. Jacobs, 212 S. Union Ave.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Adenocarcinoma of lung</i> 1629									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/21 19 82 to 8/10 19 82, that (I/we) last saw the deceased alive on 8/10 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (we) (did not) view the body after death.									
22b. SIGNATURE E. Koleszarska					22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/10/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) E. Koleszarska					22f. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug. 11, 1982		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.					25a. DATE REC'D. BY REGISTRAR AUG 11 1982		25b. REGISTRAR'S SIGNATURE John J. Smith		





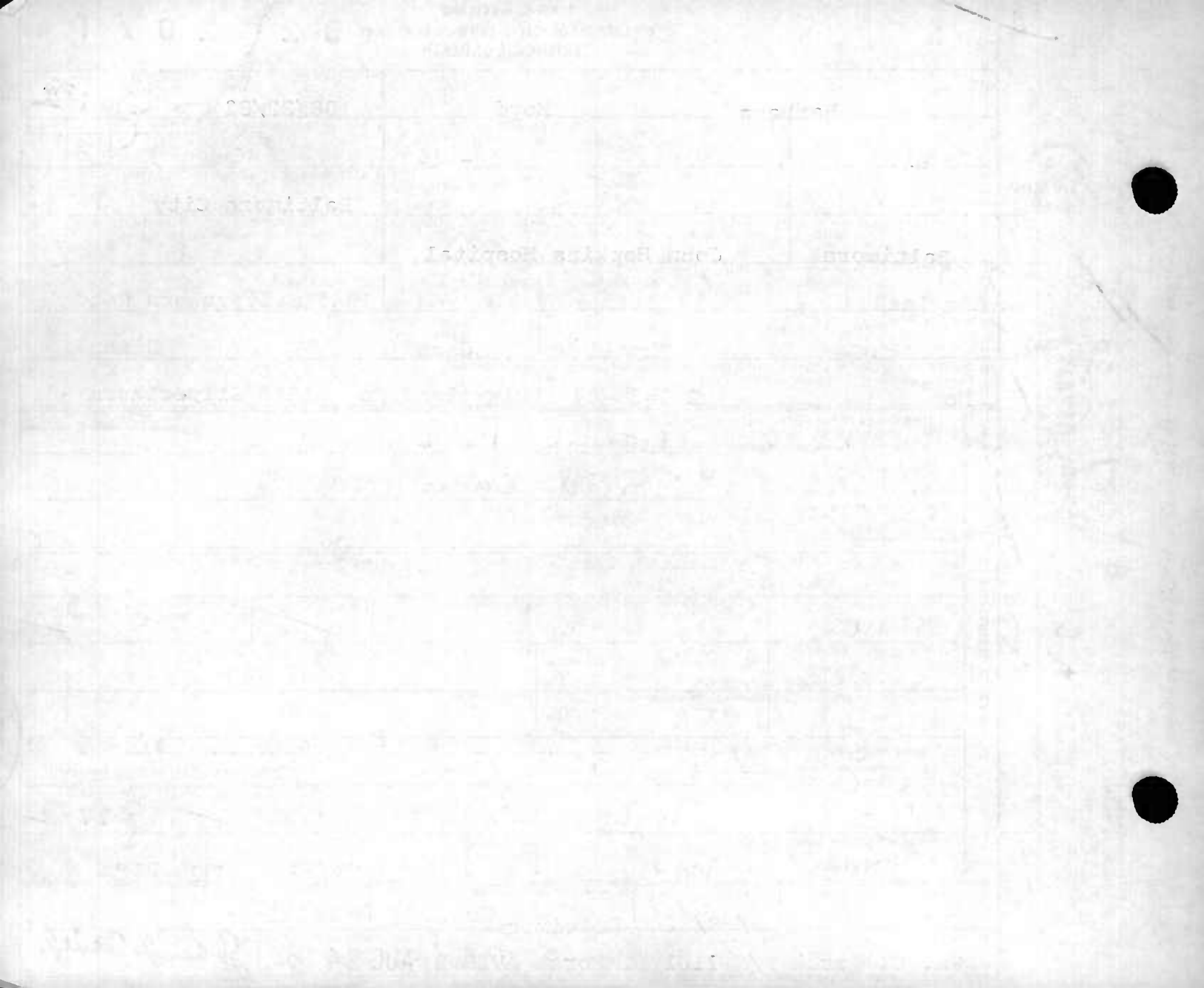
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial or disposition permit. Then please bring it to the Baltimore County Health Department, 201 W. Preston St., Baltimore, Maryland 21201, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 0 7 1 4			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
Barbara Moyd				08/22/82			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		Black		7 10- 36		46 YRS.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
S. Carolina		USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		John Hopkins Hospital					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland						Baltimore	
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Smith Phyll				Sarah Nixon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				249=58-8418		Cleveland Moyd 1345 Silverthorn Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1749</u>							
19a. DATE OF OPERATION <u>none</u>							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-8</u> , 19 <u>82</u> , to <u>8-22</u> , 19 <u>82</u> , that (I) (we) lost <u>the deceased</u> on <u>8-22</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Thomas W. Croghan MD</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>8-22-82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas Croghan</u>				22e. ADDRESS <u>Johns Hopkins Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>8/28/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u>	
24 FUNERAL DIRECTOR NAME <u>Wm. C. March F/H 1101 E. North AVENUE</u>				25a. DATE REC'D. BY REGISTRAR <u>AUG 24 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>	



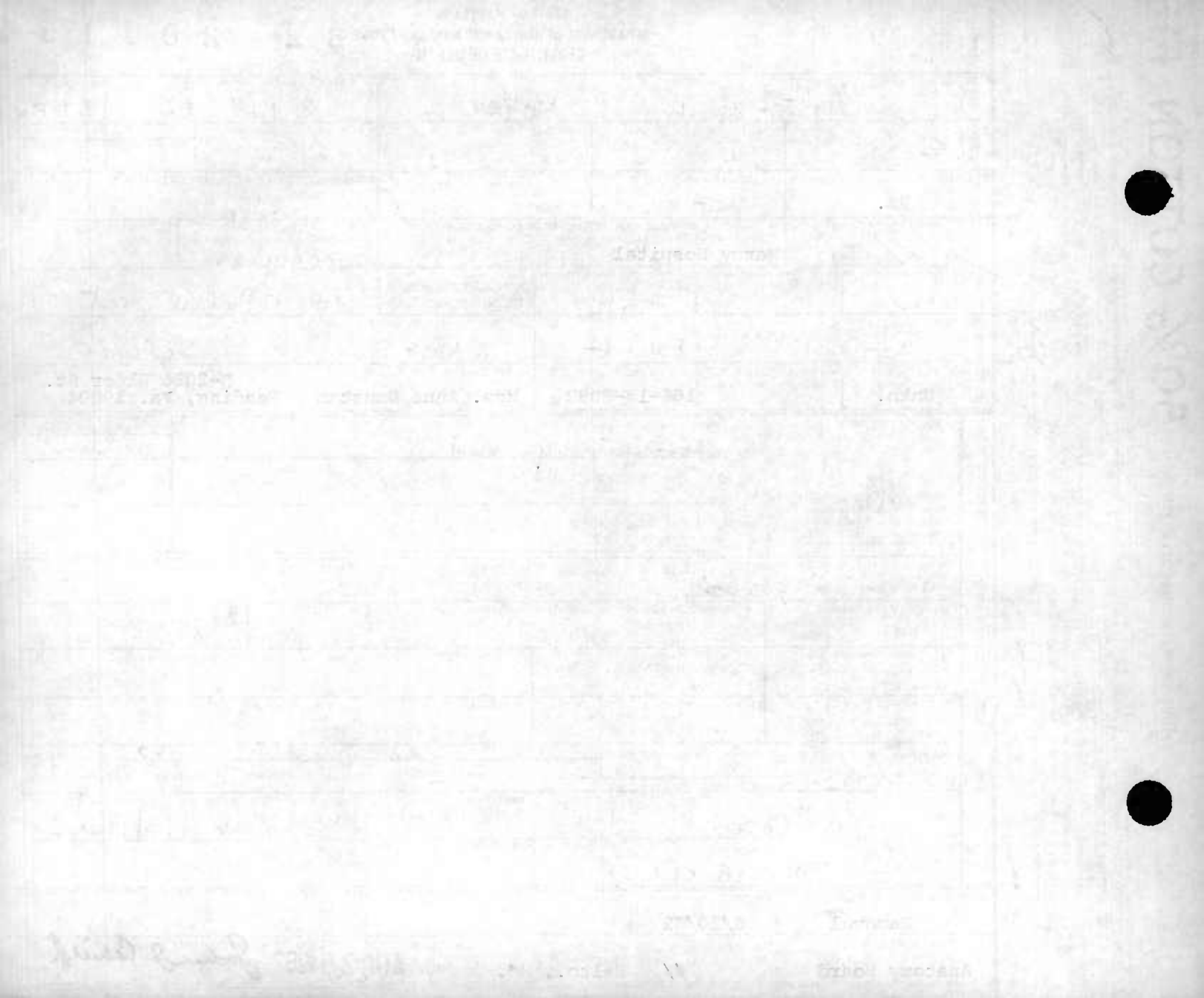


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

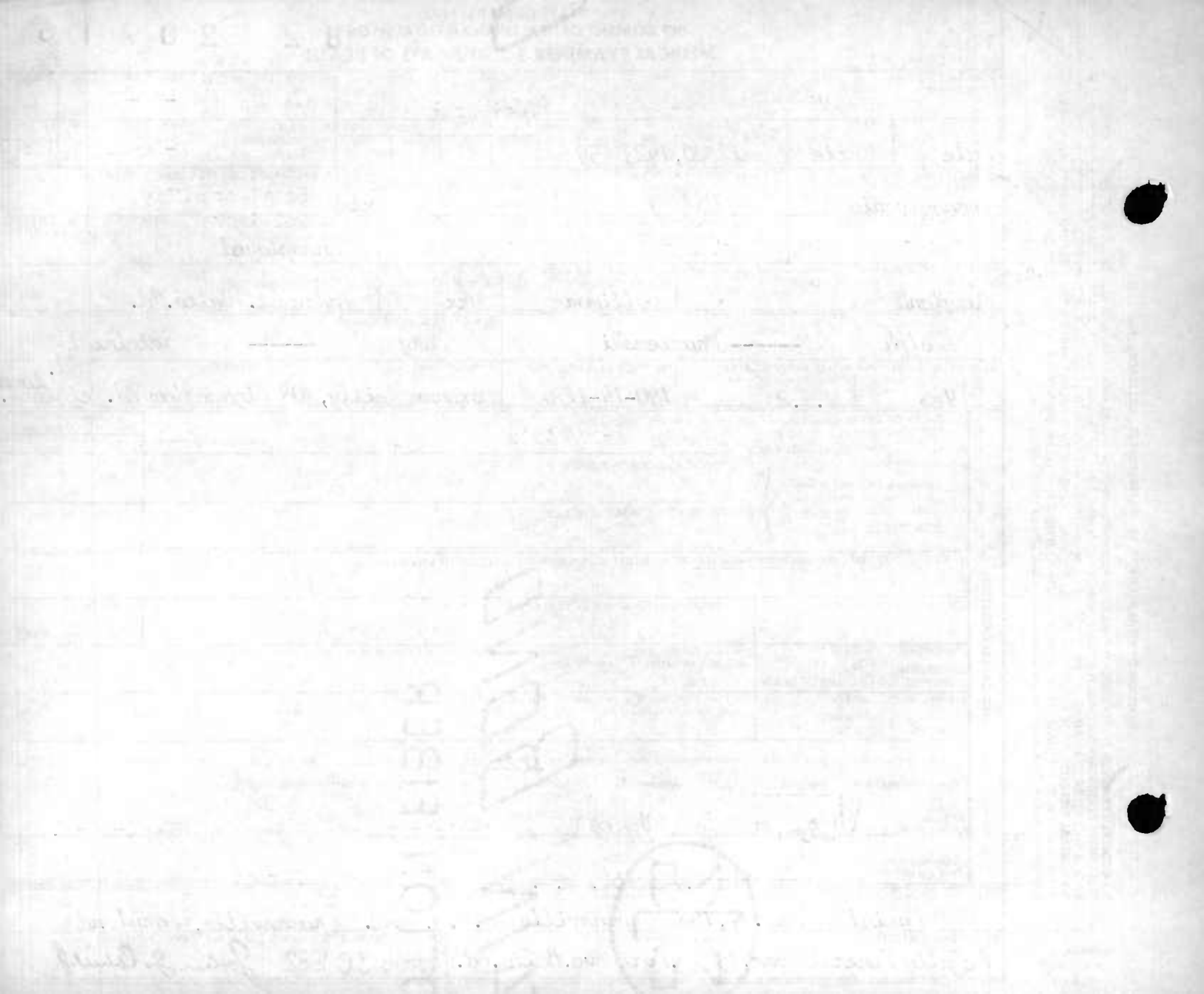
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 2 2 0 7 1 5 CERTIFICATE OF DEATH				
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH MONTH DAY YEAR				
FIRST MIDDLE LAST MARJORIE L. MOYER					8   17   82 2 40 PM				
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
♀		W		8 MONTH DAY YEAR 8 12 21		61 YRS.			
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Pa.		USA				City MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Balto. City		Mercy Hospital				homemaker			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE		13b CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
ND		Balto				309 Cathedral Street			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Walter FRUENDT				MAY Speicher					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS			
Unkn.				166-18-8092		Mrs. Anne Dunstan H-2086 Elder St. Reading, Pa. 19604			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio respiratory arrest</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____									
(c) _____									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>alcoholism, sepsis</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>8/8</u> , 19 <u>82</u> , to <u>8/17</u> , 19 <u>82</u> , that (I) (we) lost <u>above</u> , (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE				DEGREE				22c DATE SIGNED	
G Groleau								8/17/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS					
G. Groleau									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Removal		8/20/82							
24 FUNERAL DIRECTOR NAME				ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Anatomy Board				8/ Balto., Md.		AUG 25 1982		John J. Carver	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

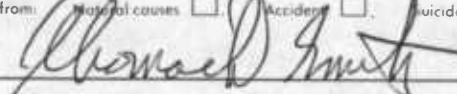
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 20716	
1. DECEASED NAME (TYPE OR PRINT) Vincent (Moreski) Mroziewski								2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 8-24-82 <sub>9</sub>		2b. HOUR 10:37 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 20, 1923		6. AGE (IN YEARS) 59 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 8-24-82 <sub>9</sub>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				9. CITIZEN OF WHAT COUNTRY? USA				10. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
11. CITY OR TOWN OF DEATH Baltimore				12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Charles and Conway Street				13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed			
14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY				13c. CITY OR TOWN Baltimore			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS Andre St. Balto. Md.							
14. FATHER'S NAME FIRST MIDDLE LAST Adolph ----- Mroziewski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary ----- Seteinski							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 100-11-2				17. INFORMANT ADDRESS Roxanne Reilly, 308 Highmeadow Rd. Reisters town, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis 5679 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margaret McNeill				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 8-24-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 31, 1982				23c. NAME OF CEMETERY OR CREMATORY Crownsville Md. V.A. Cemt.			
23d. LOCATION CITY OR TOWN County State				Crownsville, Maryland							
24. FUNERAL DIRECTOR NAME McQuilly Funeral Home, 130 E. Font Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR AUG 30 1982				25b. REGISTRAR'S SIGNATURE John J. Connelley			

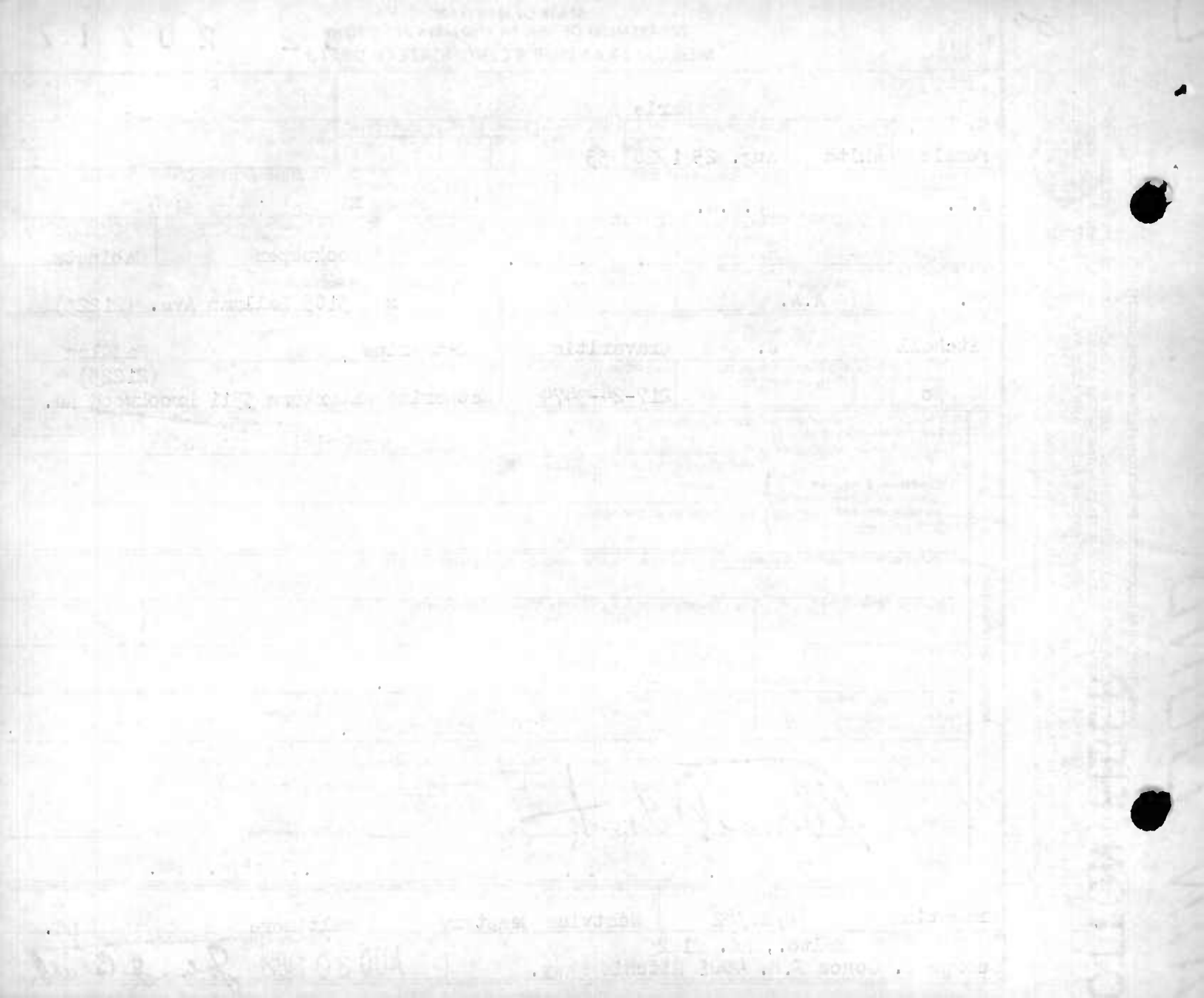


30  
38  
23  
33  
20  
2  
3

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 20717	
1. DECEASED NAME (TYPE OR PRINT) <b>ANNA Marie MULLAN</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>8</b> DAY <b>24</b> YEAR <b>1982</b>		2b. HOUR <b>M</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>25</b> YEAR <b>1928</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>53</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	IF UNDER 24 HRS. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	7c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>25</b> YEAR <b>1982</b>		7d. HOUR <b>12:20</b> <b>a</b> <b>M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balto. Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cabinets</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5109 Ballman Ave. (21225)</b>			
14. FATHER'S NAME FIRST <b>Mitchell</b> MIDDLE <b>J.</b> LAST <b>Cravaritis</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Catherine</b> MIDDLE <b></b> LAST <b>Maddlon</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-24-3474</b>		17. INFORMANT ADDRESS <b>(21225)</b> <b>Katherine Haberkorn 5311 Brookwood Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9654</b> IMMEDIATE CAUSE (a) <b>Multiple gunshot wounds (unspecified weapon)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>10</b> P.M. MONTH <b>8</b> DAY <b>24</b> YEAR <b>1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Subject shot.</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET <b>5109 Ballman Ave.</b> CITY OR TOWN <b>Anne Arundel</b> COUNTY <b>Md.</b> STATE <b>Md.</b>						
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. <b>Deputy Chief</b> MEDICAL EXAMINER			DATE SIGNED <b>8-25-82</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>8/26/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Md.</b>				
24. FUNERAL DIRECTOR NAME <b>George J. Gonce F.H. 4001 Ritchie Hgwy.</b>					25a. DATE REC'D. BY REGISTRAR <b>AUG 30 1982</b>						



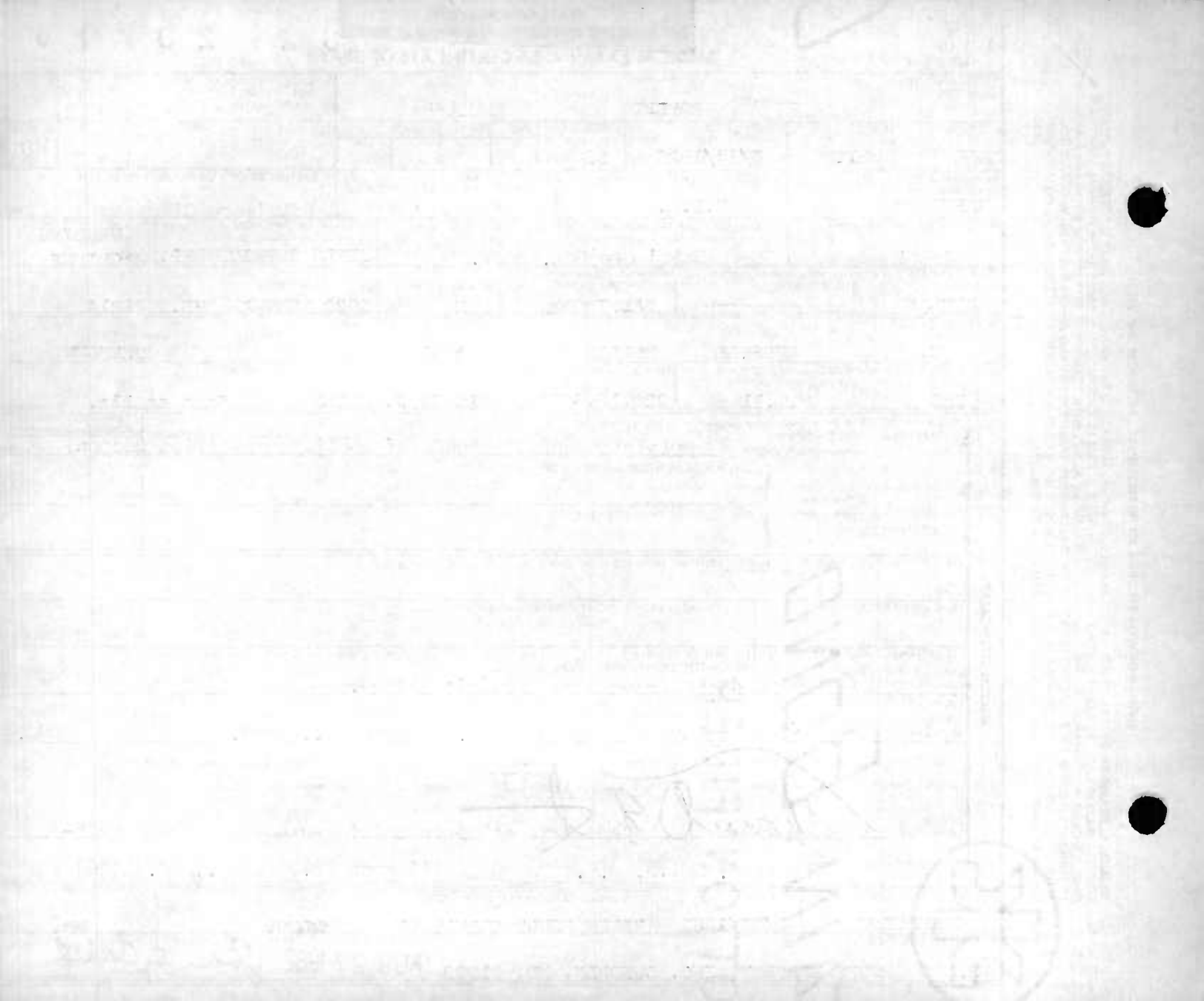


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
JAMES ROBERT MULLAN		8 24 19 82		8		24		19		82	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH	11. DAY	12. YEAR	13. HOUR	14. MIN.
MALE	WHITE	6/14/1926	56 YRS.			8 24 19 82	8	24	19	82	10:45
15. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	16. CITIZEN OF WHAT COUNTRY?	17. MARRIED	18. NEVER MARRIED	19. WIDOWED	20. DIVORCED	21. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	U.S.A.					Baltimore City MD.					
22. CITY OR TOWN OF DEATH	23. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	24. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		25. KIND OF BUSINESS		26. BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore	South Baltimore Gen. Hosp.	FIELD SERVICE REP.		MACHINES		Baltimore City MD.					
27. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	28. STATE	29. COUNTY	30. CITY OR TOWN	31. INSIDE CITY LIMITS?	32. STREET ADDRESS	33. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND			BALTIMORE	YES	5923 BERTRAM AVE. 21214	Baltimore City MD.					
34. FATHER'S NAME	35. MOTHER'S MAIDEN NAME	36. ADDRESS		37. BALTIMORE CITY OR COUNTY OF DEATH							
C. RUSSELL MULLAN	ANNA	UNKNOWN		Baltimore City MD.							
38. WAS DECEASED EVER IN U.S. ARMED FORCES?	39. SOCIAL SECURITY NO.	40. INFORMANT		41. ADDRESS							
YES	W.W.11	GLORIA J. MULLAN		Same as 13e.							
42. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
9554 IMMEDIATE CAUSE (a) Multiple gunshot wounds of chest (unspecified weapon)											
DUE TO, OR AS A CONSEQUENCE OF											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
43. DATE OF OPERATION				44. CONDITION FOR WHICH OPERATION WAS PERFORMED?				45. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
46. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				47. TIME OF INJURY				48. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				10 P.M. 8-24-1982				Self-inflicted.			
49. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				50. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				51. LOCATION			
				alley				3625 S. Hanover St., Balto. Md.			
52. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
53. ACTUAL SIGNATURE											
Thomas D. Smith, M.D.											
54. EXAMINER'S NAME (TYPE OR PRINT)											
Thomas D. Smith, M.D.											
55. ADDRESS											
111 Penn St., Balto., Md. 21201											
56. BURIAL, CREMATION, REMOVAL (SPECIFY)				57. DATE				58. NAME OF CEMETERY OR CREMATORY			
CREMATION				8/26/1982				GREEN MOUNT CREMATORY			
59. FUNERAL DIRECTOR				60. DATE REC'D. BY REGISTRAR				61. REGISTRAR'S SIGNATURE			
WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222				AUG 27 1982				John J. Connel			



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 1 9

1. FOR  
STATE  
REGISTRAR

REG. NO. 5 82

1. DECEASED NAME  
(TYPE OR PRINT)

EDWARD A. MUNCHOW JR.

MUNCHOW JR.

DATE OF DEATH

8/5/82

7b HOUR  
11:58pm3. SEX  
Male4. RACE  
Caucasian5. DATE OF BIRTH  
10-1-19136. AGE (IN YEARS LAST BIRTHDAY)  
68 yrs.IF UNDER 1 YEAR  
MONTHS DAYSIF UNDER 24 HRS.  
HOURS MIN.7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Md.7b. CITIZEN OF WHAT COUNTRY?  
USA8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH  
Baltimore City10. CITY OR TOWN OF DEATH  
Baltimore11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
Union Memorial Hospital12a. USUAL OCCUPATION  
(IF OF OTHER THAN USUAL OCCUPATION, GIVE STREET ADDRESS)  
Fireman12b. KIND OF BUSINESS OR  
INDUSTRY  
Fire Dept.13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
Md.13b. COUNTY  
Balto.13c. CITY OR TOWN  
Baltimore13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐13e. STREET ADDRESS  
3439 Ravenwood Avenue

21213

14. FATHER'S NAME  
Edward Munchow15. MOTHER'S MAIDEN NAME  
Agatha Unknown16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
no16b. SOCIAL SECURITY NO.  
212-05-778317. INFORMANT  
Mike Munchow 3439 Ravenwood Avenue

21213

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

4275  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

IMMEDIATE CAUSE (a) CARDIO / Resp arrest  
DUE TO, OR AS A CONSEQUENCE OF  
(b) uncertain  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
- 33 minPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  
none

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 1921c. HOW INJURY OCCURRED  
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/5 1982, to 8/5 1982, that (I) (we) last  
saw the deceased alive on 8/5 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above. (I) (we) did not view the body after death.

22b. SIGNATURE  
Richard A. Marasa MD

DEGREE

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐22c. DATE SIGNED  
8/6/8222d. PHYSICIAN'S NAME (TYPE OR PRINT)  
RICHARD A. MARASA MD

22e. ADDRESS

Union Memorial Hosp BALT MD

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)  
Burial23b. DATE  
8-9-8223c. NAME OF CEMETERY OR CREMATORY  
Holy Redeemer Cemetery23d. LOCATION  
CITY OR TOWN  
Balto.

COUNTY

STATE

24. FUNERAL DIRECTOR  
NAME

Schimunek Funeral Home, Inc.

3331 Brehms Lane Balto. Md. 21213

25a. DATE REC'D. BY REGISTRAR

AUG 10 1982

25b. REGISTRAR'S SIGNATURE  
John J. Conner



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 7 2 0			
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
DOROTHEA		Arleen		MURPHY				8		14	82	1:30 P.M.	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Cauc.		MONTH DAY YEAR 8 19 1925		56		MONTHS DAYS		HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Md.		USA				BALTO. CITY						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		University Hosp. MIEMSS		Homemaker		Own Home							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		Charles		Indian Head		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		34 CIRCLE Ave.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
DAVID		MARY		NO		220-16-0032		Dorothea Coleman		P.O. Box 1150		Marbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
7294		Cardiac Arrest		Neurologizing Fasciitis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-1, 19 82, to 8-14, 19 82, that (I) (we) last saw the deceased alive on 8-13, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED							
S. Wedel						8/14/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
S. Wedel M.D.		Baltimore, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		8-17-82		Old Durham Ch. Cem.		Irpnsides Charles Md.							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE					
Arehart Funeral Home		La Plata, Md.				AUG 19 1982		John J. Canish					

BP

7

Bartholomew University Hotel, Windsor

anyone who has been in the area of the incident, and if possible, the person who was driving the vehicle at the time of the incident.

04-18 200 10-10-10 10-10-10 10-10-10 10-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 2 1

REG. NO.

1. FOR STATE REGISTRAR		20. DATE OF DEATH		21. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <b>John Joseph Murphy Jr.</b>		20. DATE OF DEATH <b>August 23, 1982</b>		21. HOUR <b>M</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>March 20, 1919</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD		
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2115 Westfield Ave. (Residence)</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. State Md.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>DMV</b>		
13a. STATE <b>Md.</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2115 Westfield Ave.</b> 21214	
14. FATHER'S NAME <b>John J. Murphy Sr.</b>	15. MOTHER'S MAIDEN NAME <b>Ella V. Edenfield</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>219-03-0675</b>	17. INFORMANT ADDRESS <b>Elizabeth A. Murphy 2115 Westfield Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC ADENOCARCINOMA</b> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Nov. 19 81</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 11, 19 82</b> to <b>Aug 11, 19 82</b> , that (I) (we) first saw the deceased at <b>Aug 11, 19 82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)					
22b. SIGNATURE <b>Charles Badgett</b> MD	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>8/23/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Aug 26 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>5305 Harford Rd. Balt. Md.</b>		25. REC'D BY REGISTRAR <b>AUG 24 1982</b> REGISTRAR'S SIGNATURE <b>John J. Carver</b>			





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 signs any injury, or other traumatic cause, the deceased must be autopsied.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 0 7 2 2	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Paul A. Murphy, Jr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>08/16/82</b>			2b. HOUR <b>4:15P M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 12 40</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Comptroller</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ametek Inc.</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>13395 Triadelphia Rd. 21043</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul A. Murphy, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alma Gernais</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>217-38-1786</b>		17. INFORMANT <b>Bonnie L. Murphy</b>		17. ADDRESS <b>13395 Triadelphia Rd., Ellicott City, Md. 21043</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Card Pulm arrest</b> <b>2396</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Granstein No res</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Brain tumor</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 m</b> <b>7 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>Brain tumor</b>											
19a. DATE OF OPERATION <b>7/92</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pituitary Tumor</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>7/82</b> , 19 <b>82</b> , to <b>8/16</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>R. J. Davis</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>8/16/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Davis</b>				22e. ADDRESS <b>Johns Hopkins Hosp</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-20-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard Md.</b>					
24. FUNERAL DIRECTOR NAME <b>G. Truman Schwab</b>				3512 Frederick Ave # 21229		25a. DATE REC'D. BY REGISTRAR <b>AUG 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

MEDICAL CERTIFICATION



10000



CONFIDENTIAL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Carla Danielle Myers				2a. DATE KNOWN OF DEATH ESTIMATED 8 24 19 82				2b. HOUR 4:25 a M	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR May 11, 1962	6. AGE (IN YEARS) LAST BIRTHDAY 20 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 8 24 19 82		2d. HOUR a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Food Store	
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 103 Village of Pine Court	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred -- Myers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Ann Lee				16. ADDRESS Court, Balto, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-82-1656		17. INFORMANT Mrs. Barbara A. Myers, 103 Village of Pine			

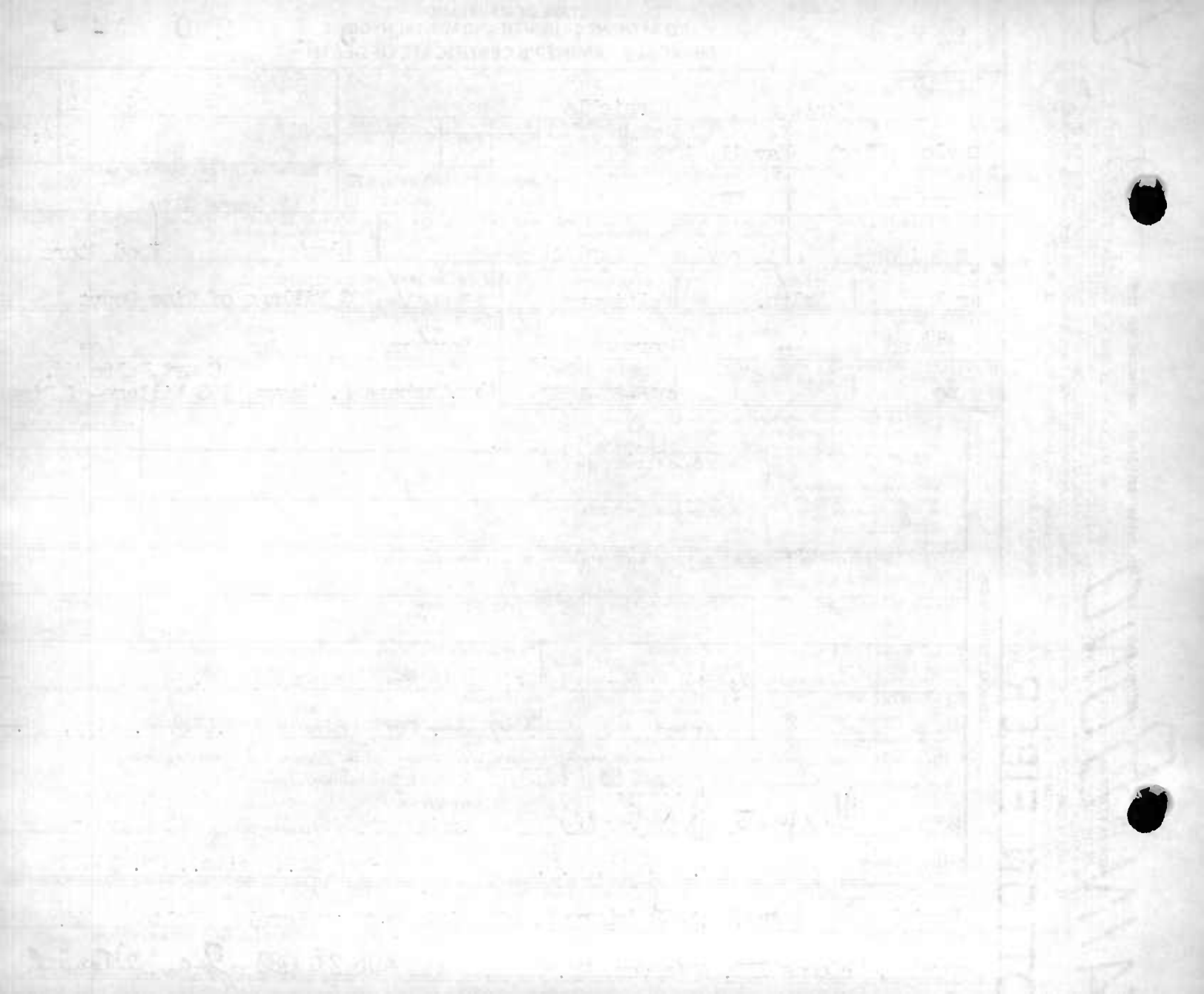
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:45 PM 8-24-1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/van collision.	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION -STREET CITY OR TOWN COUNTY STATE 3400 blk. Park Heights Ave., Balto. City, Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER DATE SIGNED 8-24-82	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St., Balto., Md. 21201					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 27, 1982		23c. NAME OF CEMETERY OR CREMATORY Asbury U. Methodist Cemetery, Lorely		23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR AUG 26 1982		25b. REGISTRAR'S SIGNATURE John J. Canary	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical certificate must be filed with the death certificate.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 2 4

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST <b>CURTIS DANIEL MYERS</b>		MONTH DAY YEAR <b>Aug 18 1982</b>		10:33 AM	
3. SEX <b>M</b>	4. RACE <b>C</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 23 51</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>30</b> YRS	7. IF UNDER 1 YEAR MONTHS DAYS <b>30</b>	8. IF UNDER 24 HRS HOURS MIN. <b>10 33</b>
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hanover</b>	10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
12. CITY OR TOWN OF DEATH <b>Baltimore</b>	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY</b>	14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Personnel Mgr. Parkin Inc.</b>			
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE <b>MD.</b>	15b. CITY OR TOWN <b>Chesapeake</b>	15c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	15d. STREET ADDRESS <b>3403 Blueberry Lane</b>		
16. FATHER'S NAME FIRST MIDDLE LAST <b>NORMAN MYERS</b>	17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>RUTH HICKS</b>				
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	18b. SOCIAL SECURITY NO. <b>213-58-1724</b>	19. INFORMANT NAME ADDRESS <b>Marcia G. Myers same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordiac arrest -</b> <b>0543</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brain stem compression 22 to hernia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Herpes encephalitis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>8/10/82</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Herpes encephalitis</b>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/10</b> , 19 <b>82</b> , to <b>8/18</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8/18</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E. Butero</b>		DEGREE		22c. DATE SIGNED <b>8/18/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Butero</b>		22e. ADDRESS <b>Univ of Md hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5-21-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster Carroll Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Fletcher F.H. 254 E. Main St. Westminster Md. 21157</b>		25. DATE REC'D BY REGISTRAR (b) REGISTRAR'S SIGNATURE <b>AUG 20 1982 [Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 2 2 0 7 2 5 CERTIFICATE OF DEATH									
REG. NO.									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Edward MIDDLE Richard LAST MYNAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
EDWARD		EDWARD		Richard Mynar		August 14, 1982		M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		AUG. 28, 1926		55 YRS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore City		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		ST. AGNES HOSPITAL				Technician		Westinghouse	
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		A.A. Co.		Linthicum		567 Forest View Road			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Edward R. Mynar		Mabel UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Same as # 13					
YES		W.W. II		220-18-6215 Mrs. Josephine P. Mynar (WIFE)					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.									
4292 IMMEDIATE CAUSE (a) CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
COPD, HX. OF ETOH ABUSE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		3:00 PM 8/14/82							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 14, 1982, to Aug 14, 1982, that (I) (we) last saw the deceased alive on Aug 14, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
Carlos G. Swantes						8/14/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Carlos Swantes		St. Agnes Hospital, Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Entombment		17 AUG '82		Cedar Hill Cem.		Brooklyn A.A. Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SINGLETON FUNERAL HOME, GLENBURNIE, MD.				AUG 17 1982		John J. Carver			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

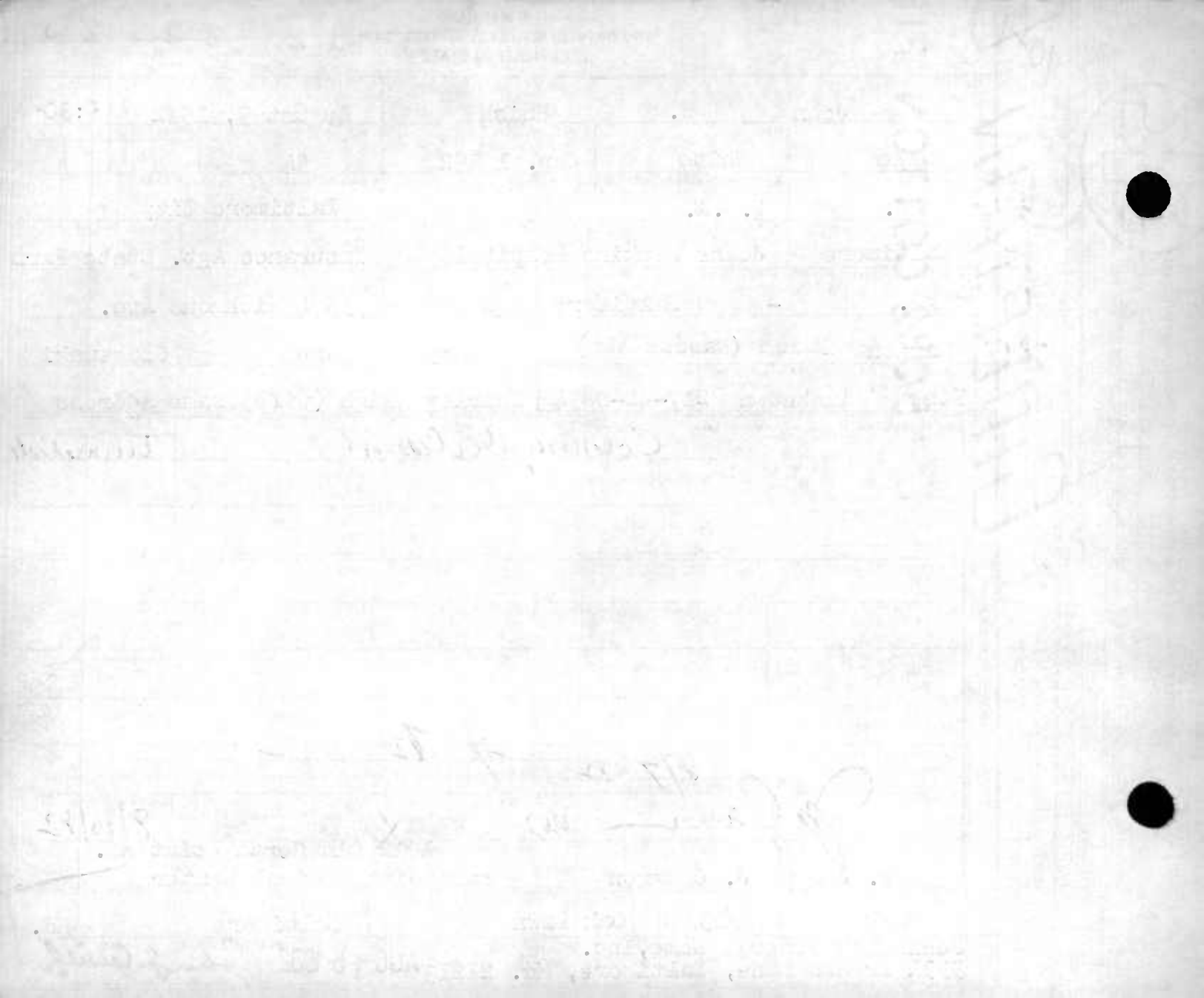
IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 2 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John W. Naish			2a. DATE OF DEATH MONTH DAY YEAR August 9, 1982		2b. HOUR 9:30 <sup>PM</sup>
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 1 1928		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	9. CITIZEN OF WHAT COUNTRY? U.S.A.	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
12. CITY OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Agt. State Farm	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Md.		15b. COUNTY -	15c. CITY OR TOWN Baltimore	15d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. FATHER'S NAME FIRST MIDDLE LAST Marion Naish (Nasazewski)		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Ozazewski			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		18b. SOCIAL SECURITY NO. unknown		19. INFORMANT ADDRESS Shirley Naish (wife) same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/7/82</u> to <u>8/10/82</u> , that (I) (we) lost saw the deceased alive on <u>8/7/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. Joseph J. Cameron</u>		DEGREE M.D.		22c. DATE SIGNED 8/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph J. Cameron		22e. ADDRESS 1012 Old North Point Rd. Eastpoint Medical Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/13/82	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Schmidiek Funeral Home, Inc. 3331 Brehms Lane, Baltimore, Md. 21213		25. DATE REC'D. BY REGISTRAR AUG 13 1982			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 0 7 2 7			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Ernestine Nash</b>				2a. DATE OF DEATH		2b. HOUR	
				MONTH DAY YEAR		110 AM	
3. SEX <b>Female</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
				MONTH DAY YEAR		89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>J. L. DEATON MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM LANE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JULIA WILLIAMS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>BERNARD NASH 2509 N. ELLAMONT ST.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHF</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MI</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <b>DCA, Dementia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> 19 <b>82</b> to <b>8/13</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/12</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>B. Deaton</b>		22c. DATE SIGNED <b>8/13/82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Brian Deaton</b>		22e. ADDRESS <b>Deaton Med Ctr 611 South Charles</b>		22f. CITY OR TOWN <b>BALTIMORE</b>		22g. STATE <b>MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8-17-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>E.L. PHILLIPS</b>				25a. DATE RECD. BY REGISTRAR <b>AUG 16 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	
1721 N. MONROE ST.							





TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 4 #G571 9/21/82 ph

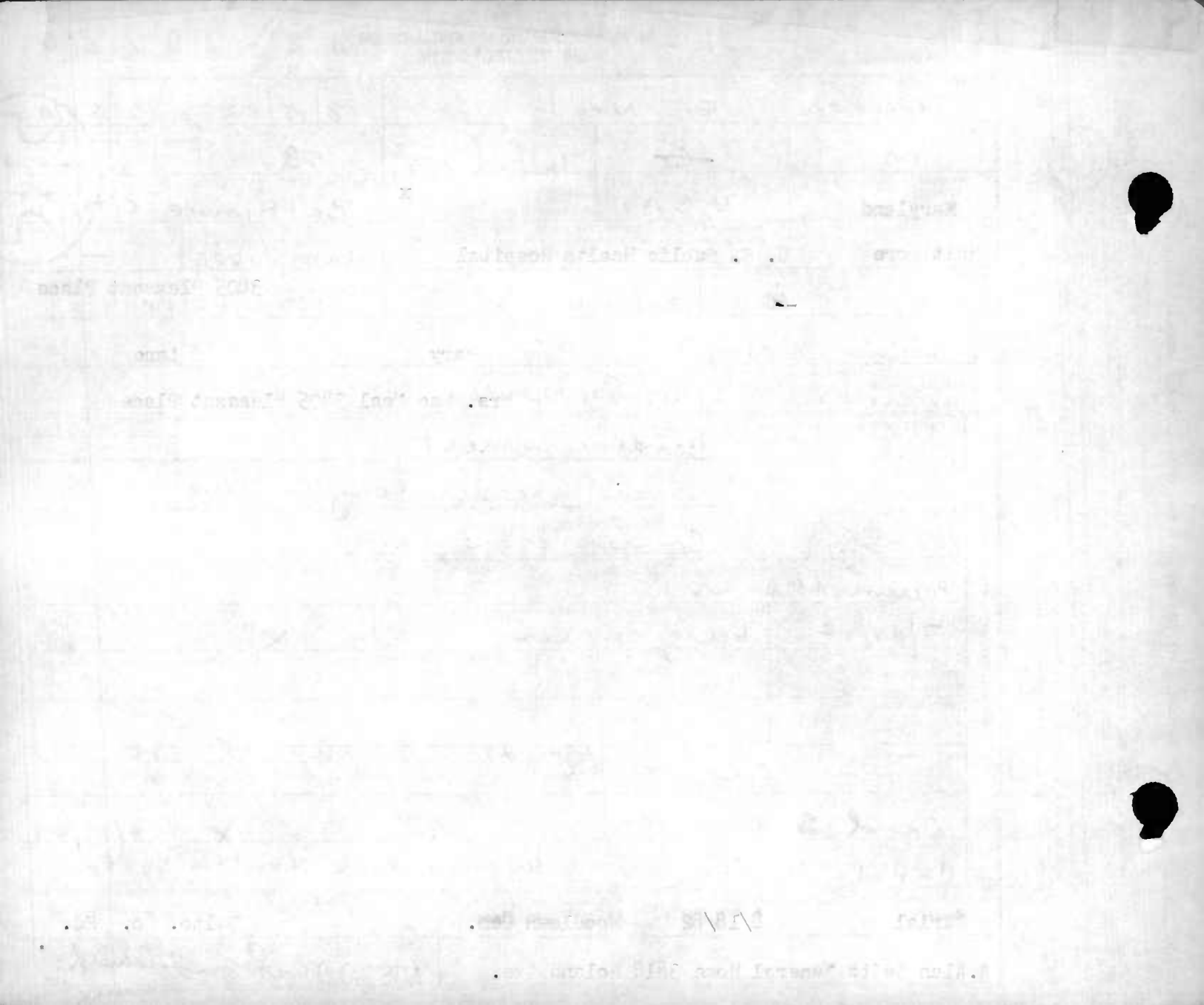
FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 1 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Gordon E. Neal</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>8/15/82</u>		2b. HOUR <u>5:07A</u> M
3. SEX <u>M</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>10/6/23</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>58</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City MD.</u>		
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>U. S. Public Health Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Unemployed</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>—</u>
13a. STATE <u>MD</u>			13b. COUNTY <u>—</u>	13c. CITY OR TOWN <u>Baltimore</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Thomas Neal</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary Lane</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>unknown</u>		16b. SOCIAL SECURITY NO. <u>217-16-6770</u>	17. INFORMANT ADDRESS <u>Mrs. Mae Neal 3805 Pleasant Place</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of the lung</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Pneumothorax</u>					
19a. DATE OF OPERATION <u>7/24/82</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>lung cancer</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>—</u> P.M. <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>May 21</u> , 19 <u>82</u> , to <u>Aug 15</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Aug 15</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Carol S. Ramsey</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/15/82</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Carol S. Ramsey</u>			22e. ADDRESS <u>Wyman Park Health System</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>8/18/82</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem..</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR NAME <u>A. Alan Seitz Funeral Home</u>			25a. DATE REC'D. BY REGISTRAR <u>Aug 20 1982</u> REGISTRAR'S SIGNATURE <u>John J. Conner</u>		
ADDRESS <u>3818 Roland Ave.</u>					



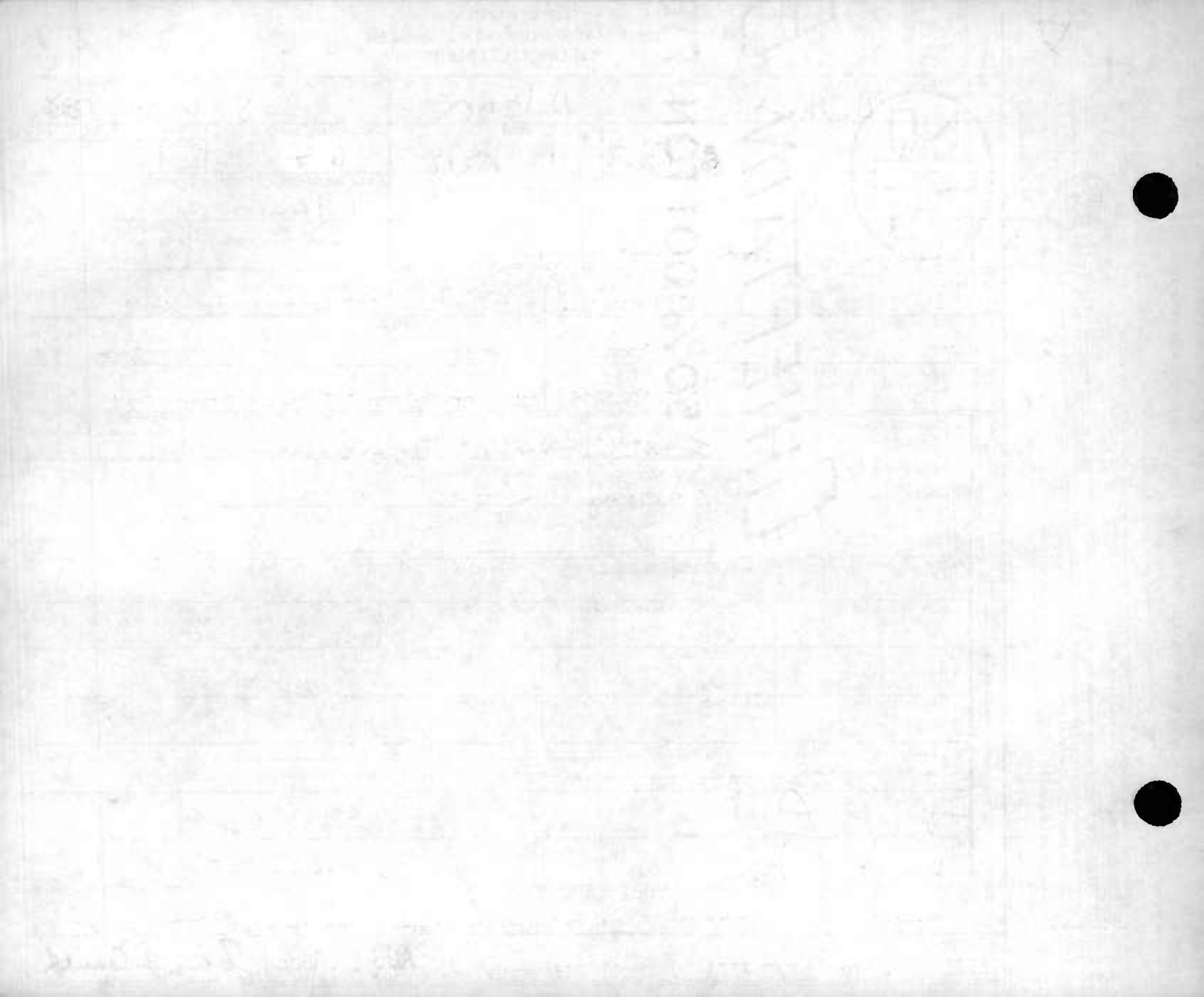


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				82 20729 REG. NO.						
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 8 6 82				2b. HOUR 1858 M		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herbert Nelson				3. SEX M				4. RACE Black		
5. DATE OF BIRTH MONTH DAY YEAR 11 15 17				6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.				7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		
7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY				13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 117 LaRae Square South				14. FATHER'S NAME FIRST MIDDLE LAST Ranson Nelson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Nelson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 248-12-2886				17. INFORMANT ADDRESS Ruth Mar Nelson 117 LaRue Square South		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal Ventral Tachycardia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4254 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy</u>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>John E. Linder</u> DEGREE <u>MD</u>						22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Harold E. Linder</u>						22e. ADDRESS <u>3001 S Hanover St Baltimore</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/12/82			23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md	
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Avenue						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 11 1982 <u>John J. Conner</u>				



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

2 0 7 3 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
MALLON Arthur				NELSON	8 19 82					10:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Black		1 MONTH 24 DAY 1902		80 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
South Carolina		U. S. A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Provident Hospital				Steel Worker		U.S. Steel			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3909 Duvall Avenue Baltimore, Maryland 21215			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Lawrence Rainey Nelson				Elizabeth Rush							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT					
No				191-03-3846		Baltimore, Maryland 21215 Mrs. Celestine Rose 3909 Duvall Ave.					

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>August 11, 19 82</u> to <u>August 19, 19 82</u> , that (I) (we) last saw the deceased alive on <u>August 19, 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frantz Celestin M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANTZ CELESTIN				22e. ADDRESS NURSES RESIDENCE, 3100 TOWANDA AVE # 309			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		8/23/82		Maryland Nat. Mem. Pk.		Anne Arundel Co., Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HENRY E. NATTER, BALTIMORE, MARYLAND 21216				AUG 20 1982		John J. Canine	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) ERIC LEVI NICKEY			2a. DATE OF DEATH MONTH DAY YEAR 8/9/82			2b. HOUR 7:39 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 3 82		6. AGE (IN YEARS LAST BIRTHDAY) YRS. DAYS 6 6		7. IF UNDER 1 YEAR MONTHS DAYS 6 6	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
12. CITY OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Agnes Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ---		15. KIND OF BUSINESS OR INDUSTRY ---	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1802 Letitia Avenue		13e. ZIP CODE 21230	
14. FATHER'S NAME FIRST MIDDLE LAST Douglas A. Nickey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Debra A. Gary		16. ADDRESS 21230 Douglas A. Nickey 1802 Letitia Avenue					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Douglas A. Nickey 1802 Letitia Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7690 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory distress Syndrome, Bilateral Pneumothorax DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/3/82 19 to 8/9/ 19 82 that (I) (we) lost saw the deceased alive on 8/9/ 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. S. Dillon		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/10/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) APS Dillon		22e. ADDRESS St Agnes Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/12/82		23c. NAME OF CEMETERY OR CREMATORY Meadowbranch Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		24b. ADDRESS 21229		25a. DATE RECD. BY REGISTRAR AUG 11 1982		25b. REGISTRAR'S SIGNATURE John J. Canfield			

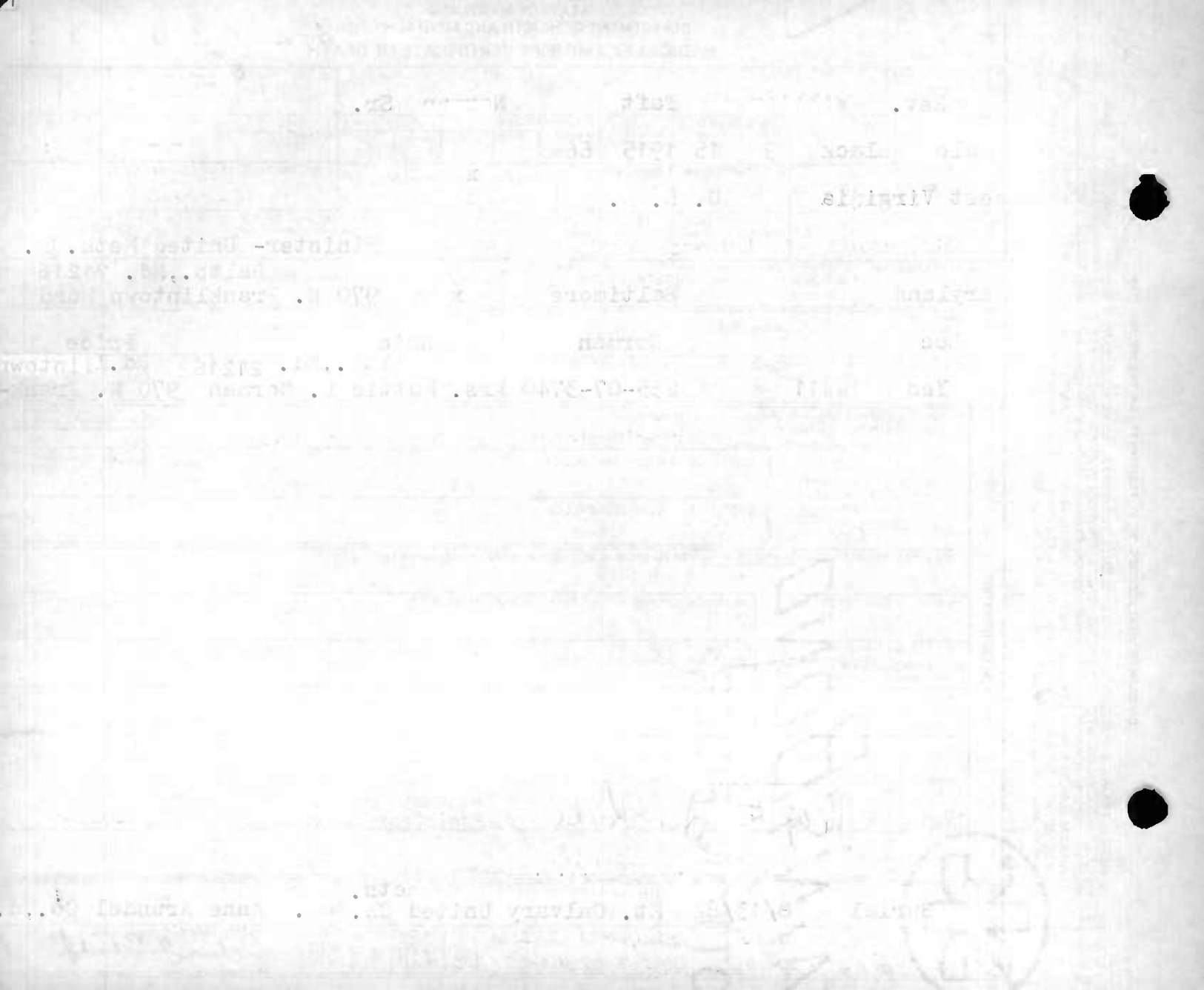




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 20732	
1. DECEASED NAME (TYPE OR PRINT) <b>Rev. William Taft Norman Sr.</b>							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>8-9-82</b>		2b. HOUR <b>5:26 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>15</b> YEAR <b>1915</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>66</b> RS.		7c. DATE PRONOUNCED DEAD <b>8-9-82</b>		2d. HOUR <b>5:26 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Minister- United Meth.Ch.</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Balto., Md. 21216</b>		
14. FATHER'S NAME FIRST <b>Doc</b> MIDDLE LAST <b>Norman</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Annie</b> MIDDLE LAST <b>Price</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW11</b>			16b. SOCIAL SECURITY NO. <b>235-07-3740</b>		
17. INFORMANT <b>Balto., Md. 21216</b>			17. INFORMANT <b>Rd. lintown</b>			17. INFORMANT <b>Mrs. Mattie L. Norman</b>			17. INFORMANT <b>970 N. Frank-</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>						TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>8-10-82</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>						ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary United Ch. Cem.</b>				23d. LOCATION CITY OR TOWN <b>Anne Arundel Co. Md.</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>HERBERT E. NUTTER FUNERAL HOME</b>						ADDRESS <b>BALTIMORE MARYLAND 21216</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1982</b>		
25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 20733 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Norman J. North</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 27 82</b>		2b. HOUR <b>2<sup>30</sup> am</b>
3. SEX <b>male</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 14 26</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>National Vinyl Co.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>	13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Randallstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>3808 Elmcroft Rd</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Justus North</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY PALEN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW II</b>		16b. SOCIAL SECURITY NO. <b>123-16-3243</b>		17. INFORMANT ADDRESS <b>Mrs. Patricia M. Hudson 3808 Elmcroft Rd., Randallstown, MD 21133</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>1629 IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LUNG CA</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pneumonia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/24</b> , 19 <b>82</b> , to <b>8/27</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/27</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>G Groleau MD</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/27/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G Groleau MD</b>		22e. ADDRESS <b>Mercy Hospital 301 St Paul</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/30/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Pk.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Carroll MD</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Rd., Randallstown, MD 21133</b>			
24. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>SEP 1 1982</b>		25c. REGISTRAR'S SIGNATURE <b>Joan J. Conner</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 7 3 4	
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HILDA NOWELL						2a DATE OF DEATH MONTH DAY YEAR 8/10/82				2b HOUR 1:20 M	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 10-12-11		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10 CITY OR TOWN OF DEATH BALTO. CITY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a USUAL OCCUPATION (NATURE OF WORK OR MOST OF WORKING LIFE) Housewife			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland						13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST William Washington						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UN KNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b SOCIAL SECURITY NO. 215-14-7988A		17 INFORMANT ADDRESS Edward Nowell 14			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intractable Ventricular Fibrillation</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> 8/6/82 DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Long History of Angina; Breast Cancer</u>											
19a DATE OF OPERATION 8/6/82				19b CONDITION FOR WHICH OPERATION WAS PERFORMED Pathological Fracture Femur				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>8/11</u> , 19 <u>82</u> , to <u>8/10</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/10</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Charles Denny						DEGREE		22c DATE SIGNED 8/10/82		22d PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES DENNY M.D.	
22e ADDRESS 201 UNIVERSITY PARKWAY											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 8-14-82		23c NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery				23d LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL Co. Md.	
24 FUNERAL DIRECTOR NAME William J. Sperry						ADDRESS 1639 N. Broadway		25a REC'D. BY REGISTRAR AUG 12 1982		25b REGISTRAR'S SIGNATURE John J. Carver	



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 0 7 3 5  
CERTIFICATE OF DEATH

1. FOR STATE REGISTER		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST JOHN Joseph NULL		MONTH DAY YEAR 8-26-82	
3. SEX Male		2b. HOUR 7 <sup>20</sup> A.M.	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR 10 / 2 / 1907		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Contractor	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY OR TOWN Baltimore	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3415 Chestnut Ave. 21211	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Michael Null		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aramanda Switzer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 190.05.3345	
17. INFORMANT James W. Null		ADDRESS Melbourne Beach, Fla. 32951	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4413 IMMEDIATE CAUSE (a) Cardiac ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Haemorrhagic Shock DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured Abdominal Aortic Aneurysm		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hour.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. Abdominal Aortic Aneurysm			
19a. DATE OF OPERATION 8/26/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aortic Aneurysm	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 8/26 19 82 to 8/26 19 82, that (I) (we) last saw the deceased alive on 8/26 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.			
22a. SIGNATURE RAIKAR. R. V.		22b. DATE SIGNED 8/26/82	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) RAIKAR. R. V.		22d. ADDRESS 201 EAST UNIVERSITY PLWAY UMH. Baltimore MD 21218	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/27/82	
23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD	
24. FUNERAL DIRECTOR Walter Brooks Bradley, Inc. Balto. MD		25a. DATE REC'D. BY REGISTRAR AUG 27 1982	
25b. REGISTRAR'S SIGNATURE John J. Givich			



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

REPORT OF THE  
COMMISSIONER OF PLANT INDUSTRY  
FOR THE YEAR 1911

THE COMMISSIONER OF PLANT INDUSTRY  
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF  
THE FOLLOWING REPORTS:

REPORT OF THE  
COMMISSIONER OF PLANT INDUSTRY  
FOR THE YEAR 1911

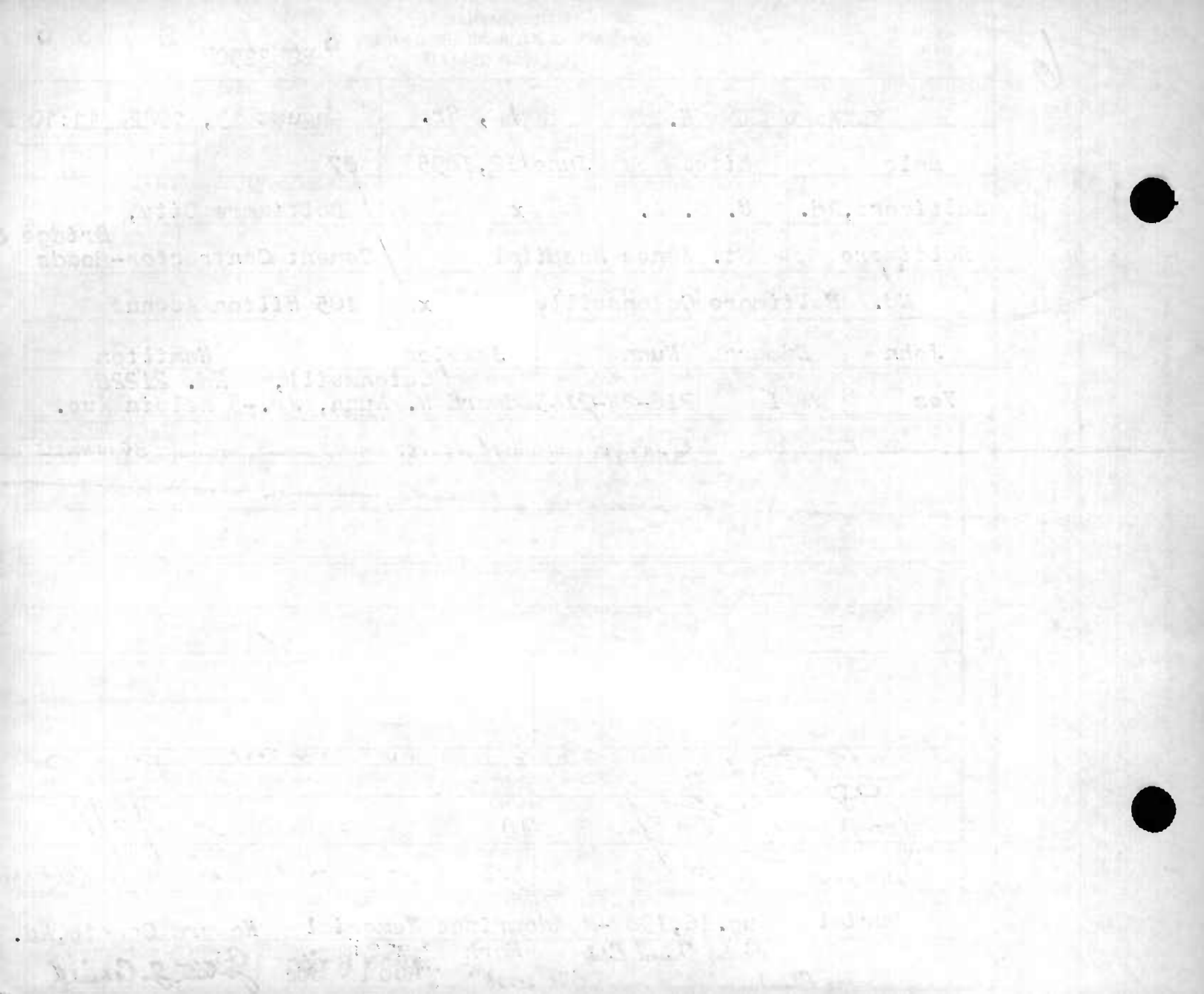
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 0 7 3 6 REG. NO. E0532904			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MMM EDWARD H. NUNN, Sr.				2a. DATE OF DEATH MONTH DAY YEAR August 13, 1982		2b. HOUR 11:10 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 12, 1895		6. AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cement Contractor-Roads		12b. KIND OF INDUSTRY Bridge &	
13a. STATE Md.				13b. CITY OR TOWN Catonsville		13c. STREET ADDRESS 105 Hilton Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST John Edward Nunn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessica Hamilton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT ADDRESS Catonsville, Md. 21228 Edward H. Nunn, Jr.-5 Melvin Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 13 August 1982, to 13 August 1982, that (I) (we) saw the deceased alive on 13 August 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Andrew Trofa		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Trofa		22e. ADDRESS 900 Cason Ave. Baltimore MD 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 16, 1982		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Howard County, Md.	
24. FUNERAL DIRECTOR NAME Sterling Funeral Home		24b. ADDRESS 745 Edmonson Ave. Catonsville, MD 21228		25a. DATE REC'D. BY REGISTRAR AUG 16 1982		25b. REGISTRAR'S SIGNATURE John J. Caswell	



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 7 3 7 REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) <b>REV. George Vincent</b>				2a. DATE OF DEATH MONTH <b>8</b> DAY <b>1</b> YEAR <b>82</b>		2b. HOUR <b>10 34 A.M.</b>		
3. SEX <b>m</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>20</b> YEAR <b>05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Priest Roman Catholic</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Millersville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>25 HIGHLAND DR MILLERSVILLE, MD</b>			
14. FATHER'S NAME FIRST <b>ALBERT</b> MIDDLE <b>Joseph</b> LAST <b>OVERLE</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Katherine</b> MIDDLE <b>O'Neil</b> LAST <b>ALLEN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-48-0023</b>		17. INFORMANT <b>Rev. William J. Lee, S.S.,</b>				ADDRESS <b>5408 Roland Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min - 1 hr</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>congestive heart failure</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerotic cardiovascular heart disease</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>7-16</b> , 19 <b>82</b> , to <b>8/1</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>7/30</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>D. Stern MD</b>						DEGREE		22c. DATE SIGNED <b>8/1/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. STERN MD</b>						22e. ADDRESS <b>3001 S. Hanover Street Balto., Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-5-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sulpician</b>		23d. LOCATION CITY OR TOWN <b>Catonsville</b> COUNTY <b>Md.</b> STATE					
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG - 3 1982</b> 25b. SIGNED BY REGISTRAR <b>Theresa J. [Signature]</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in this 72 hour register with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filled out and signed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 0 7 3 8			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
JAMES WILLIAM O'Bitz, Sr.								08-04-82				6:30pm	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		June 17, 1902		80		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Baltimore City, MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		Church Home & Hospital		Welsh Construction Co.									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Baltimore		Middle River		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3503 Beach Road					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
Lawrence		Caroline		No		217-05-2310A		Mrs. Helen K. O'Bitz		Same as # 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. DUE TO, OR AS A CONSEQUENCE OF		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4280		BILATERAL PNEUMONIA		CONGESTIVE HEART FAILURE, OLD CEREBRAL		VASCULAR ACCIDENT (STROKE) PANCREATITIS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) this hospital attended the deceased from 07-19-82 to 08-04-82, that (1) (we) last saw the deceased on 08-04-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE (TYPE)		DEGREE		22c. DATE SIGNED							
						8/4/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
DR. I. WALKER M.D.		100 N. BROADWAY BALTIMORE, MARYLAND 21231											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		8-7-82		Gardens of Faith		Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Leonard J. Ruck, Inc.		Baltimore, Md.		AUG - 6 1982		John J. Connel							

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*Handwritten signature*

2004 COLLECTION

WILKINSON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 3 9

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
Dorothy L. O'Brien		8/10/82		11:43 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
F	White	MONTH DAY YEAR	76 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
W. Virginia	U. S. A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Balto.	St. Agnes Hospital		Office-May Co. Dept. Store		
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS		
Md.	How	Ellicott City	3252 D.-Normandy Wood Drive		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Joseph Landon		Estelle Youse			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
		218-28-1823A	3252 D.-Normandy Wood Drive, Mr. Walter T. O'Brien Ellicott City, Md. 21043		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
4140 IMMEDIATE CAUSE (a) Cardiac arrest					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Intractable CHF + Pleural effusion					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Atherosclerotic coronary artery disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
chr. renal failure, hypermagnesemia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19b. PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/8 to 8/10, 1982, that I (we) last saw the deceased alive on 8/10, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Forster		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		8/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
PURUSHOTTAM MITRA		1143			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		8-13-82	Lorraine Park Cem.		Balto. Md.
24. FUNERAL DIRECTOR NAME		3512 Frederick Ave. #21229		25a. DATE RECEIVED BY REGISTRAR	
G. Truman Schwab, P.A.				AUG 24 1982	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without delay after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, steps only injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

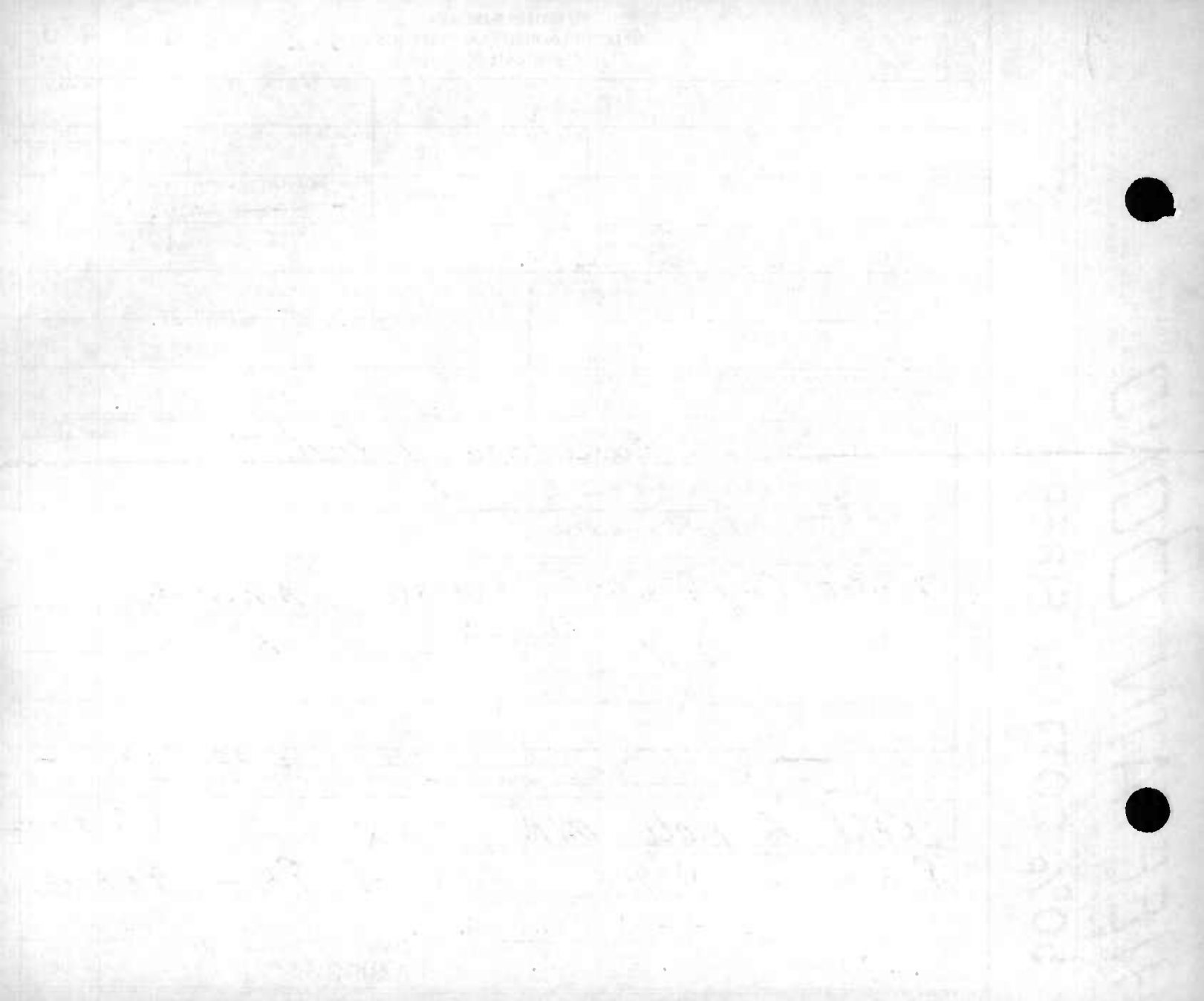
REG. NO.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CONNIE ODELL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 21 82</b>                   |   | 2b. HOUR<br>M<br><b>M</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 21 14</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>67</b>         |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>1 WEST CONWAY ST. City MD.</b> |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2019 DRUID HILL AVE.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)        |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b> |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>COLUMBUS O'DELL</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HATTIE HAIRSTON</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br><b>ROBERTA SCOTT 1634 BALMOR CT.</b>          |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1850</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

|   |   |  |   |
|---|---|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Melanotic Ca of Prostate - ASCURED - Anemia</b>   |   |  |   |
| 19a. DATE OF OPERATION<br><b>8/2/82</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ca of Prostate</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/1/82</b> to <b>8-22</b> , 19 <b>82</b> , that (I) <del>was</del> last saw the deceased alive on <b>8/17</b> , 19 <b>82</b> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (If <del>not</del> <del>not</del> did not view the body after death.) |   |  |   |
| 22b. SIGNATURE<br><b>Robert L. Doyle MD</b>   |   | 22c. DATE SIGNED<br><b>8-23-82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT L DOYLE</b>  |   | 22e. ADDRESS<br><b>333 ST. PAUL PLACE</b>  |   |

|  |                               |   |   |
|--|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>ENTOMBMENT        | 23b. DATE<br><b>8 8-25-82</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM. PK.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E.L. PHILLIPS</b> |                               | 24b. ADDRESS<br><b>1721 N. MONROE ST.</b>                     | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 23 1982</b>                     |
|  |                               | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>              |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |                             |   |   |   |  |  |  | 8 2 2 0 7 4 1  |  |
|---|--|--|-----------------------------|---|---|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |                             |   |   |   |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHRISTIAN OPPELT</b>  |  |  |                             |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>AUGUST 25, 1982</b>  |  |  | 2b. HOUR<br><b>1:00 a.m.</b>                       |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |                             | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 9 99</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |  | MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |                             |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Brewer</b> |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |                             |   |   | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Johann Oppelt</b>  |  |  |                             |   |   | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Margareta Long</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |                             | 16b. SOCIAL SECURITY NO.<br><b>215-03-7608</b>  |   | 17. INFORMANT ADDRESS<br><b>Margareta Oppelt 334 S. East Avenue 21224</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>5570</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DIC</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEPSIS</b>  |  |  |                             |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><b>EMPYEMA PERITONITIS ASCVD COPD</b>   |  |  |                             |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>8-11 7-29 7-19</b>   |  |  |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GANGRENE SMALL BOWEL ANASTOMOTIC LEAU TRACHEOSTOMY</b>   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |                             | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>no injury</b> |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-8</b> , 19 <b>82</b> , to <b>8-25</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8-25</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                             |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>K George Gudma</b>   |  |  |                             |   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/25/92</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K GEORGE THOMAS MD.</b>   |  |  |                             |   |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION 100 NORTH BROADWAY BALTIMORE Md. 21231</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>8-28-82</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b> |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Md.</b>                              |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>C.S. Zeiler &amp; Son Inc. 901 S. Conkling Street</b>   |  |  |                             |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 27 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conkling</b>  |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR AIS ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |   |  |   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
|--|---------|---|--|---|--|-----------------------------------|--|---|--|--------------------------|--|-------|--|-----|--|------|--|------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   |  | MIDDLE  |  | LAST                              |  | 2a. DATE KNOWN OF DEATH   |  | 2b. DATE ESTIMATED       |  | MONTH |  | DAY |  | YEAR |  | 2d. HOUR   |  |
| Harry  |         | S.  |  | Orloff, Jr.   |  |                                   |  | 8   |  | 18                       |  | 19    |  | 82  |  |      |  |            |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                    |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY |  | YEAR |  | 2d. HOUR   |  |
| Male   | White   | 1 1 52  |  | 30 YRS.   |  |                                   |  |   |  | 8                        |  | 18    |  | 19  |  | 82   |  | 11:37 P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                          |  |       |  |     |  |      |  |            |  |
| N.Y.   |         | USA   |  | WIDOWED   |  | DIVORCED                          |  | Baltimore City,   |  |                          |  |       |  |     |  |      |  |            |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| Baltimore  |         | Johns Hopkins Hospital                                      |  |   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                 |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS      |  |       |  |     |  |      |  |            |  |
| N.Y.   |         |   |  |   |  | Valley Falls                      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 634 Hoag Rd.             |  |       |  |     |  |      |  |            |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| Harry  |         | S.  |  | Orloff, Sr.   |  | Betty                             |  | Lou   |  | Brachard                 |  |       |  |     |  |      |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS                           |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| No   |         |   |  |   |  | Harry S. Orloff, Sr.              |  | 634 Hoag Rd.  |  |                          |  |       |  |     |  |      |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple stab wounds</u><br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> .<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |         |   |  |   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |   |  |   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
|  |         |   |  |   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
|  |         | HOUR <u>XX</u> MONTH DAY YEAR                               |  | Subject stabbed   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  | CITY OR TOWN                      |  | COUNTY  |  | STATE                    |  |       |  |     |  |      |  |            |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         | jail  |  | 954 Forrest St.   |  | Balto.                            |  |   |  | Md.                      |  |       |  |     |  |      |  |            |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |  |   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |  | DATE SIGNED   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
|  |         | M.D. Assistant  |  | 8/19/82   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |  |   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| Ann M. Dixon, M.D.   |         | III Penn St.  |  | Balto., MD.   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION                     |  | CITY OR TOWN  |  | COUNTY                   |  | STATE |  |     |  |      |  |            |  |
| BURIAL   |         | 8/23/82   |  | Waterford Rural Cem   |  | Waterford                         |  |   |  |                          |  | N.Y.  |  |     |  |      |  |            |  |
| 24. FUNERAL DIRECTOR NAME  |         | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE        |  |   |  |                          |  |       |  |     |  |      |  |            |  |
| Wm. C. March F/H   |         | 1101 E. North Avenue  |  | AUG 20 1982   |  |                                   |  |   |  |                          |  |       |  |     |  |      |  |            |  |



1. Name of Patient: [illegible]  
2. Date of Birth: [illegible]  
3. Social Security Number: [illegible]  
4. Service Number: [illegible]  
5. Branch of Service: [illegible]  
6. Grade or Rate: [illegible]  
7. Component: [illegible]  
8. Duty Station: [illegible]  
9. Date of Admission: [illegible]  
10. Date of Discharge: [illegible]

11. Name of Referring Physician: [illegible]  
12. Name of Referring Hospital: [illegible]  
13. Name of Referring Clinic: [illegible]  
14. Name of Referring Office: [illegible]  
15. Name of Referring Department: [illegible]  
16. Name of Referring Branch: [illegible]  
17. Name of Referring Component: [illegible]  
18. Name of Referring Duty Station: [illegible]  
19. Name of Referring Date of Admission: [illegible]  
20. Name of Referring Date of Discharge: [illegible]

21. Name of Referring Physician: [illegible]  
22. Name of Referring Hospital: [illegible]  
23. Name of Referring Clinic: [illegible]  
24. Name of Referring Office: [illegible]  
25. Name of Referring Department: [illegible]  
26. Name of Referring Branch: [illegible]  
27. Name of Referring Component: [illegible]  
28. Name of Referring Duty Station: [illegible]  
29. Name of Referring Date of Admission: [illegible]  
30. Name of Referring Date of Discharge: [illegible]

31. Name of Referring Physician: [illegible]  
32. Name of Referring Hospital: [illegible]  
33. Name of Referring Clinic: [illegible]  
34. Name of Referring Office: [illegible]  
35. Name of Referring Department: [illegible]  
36. Name of Referring Branch: [illegible]  
37. Name of Referring Component: [illegible]  
38. Name of Referring Duty Station: [illegible]  
39. Name of Referring Date of Admission: [illegible]  
40. Name of Referring Date of Discharge: [illegible]

41. Name of Referring Physician: [illegible]  
42. Name of Referring Hospital: [illegible]  
43. Name of Referring Clinic: [illegible]  
44. Name of Referring Office: [illegible]  
45. Name of Referring Department: [illegible]  
46. Name of Referring Branch: [illegible]  
47. Name of Referring Component: [illegible]  
48. Name of Referring Duty Station: [illegible]  
49. Name of Referring Date of Admission: [illegible]  
50. Name of Referring Date of Discharge: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

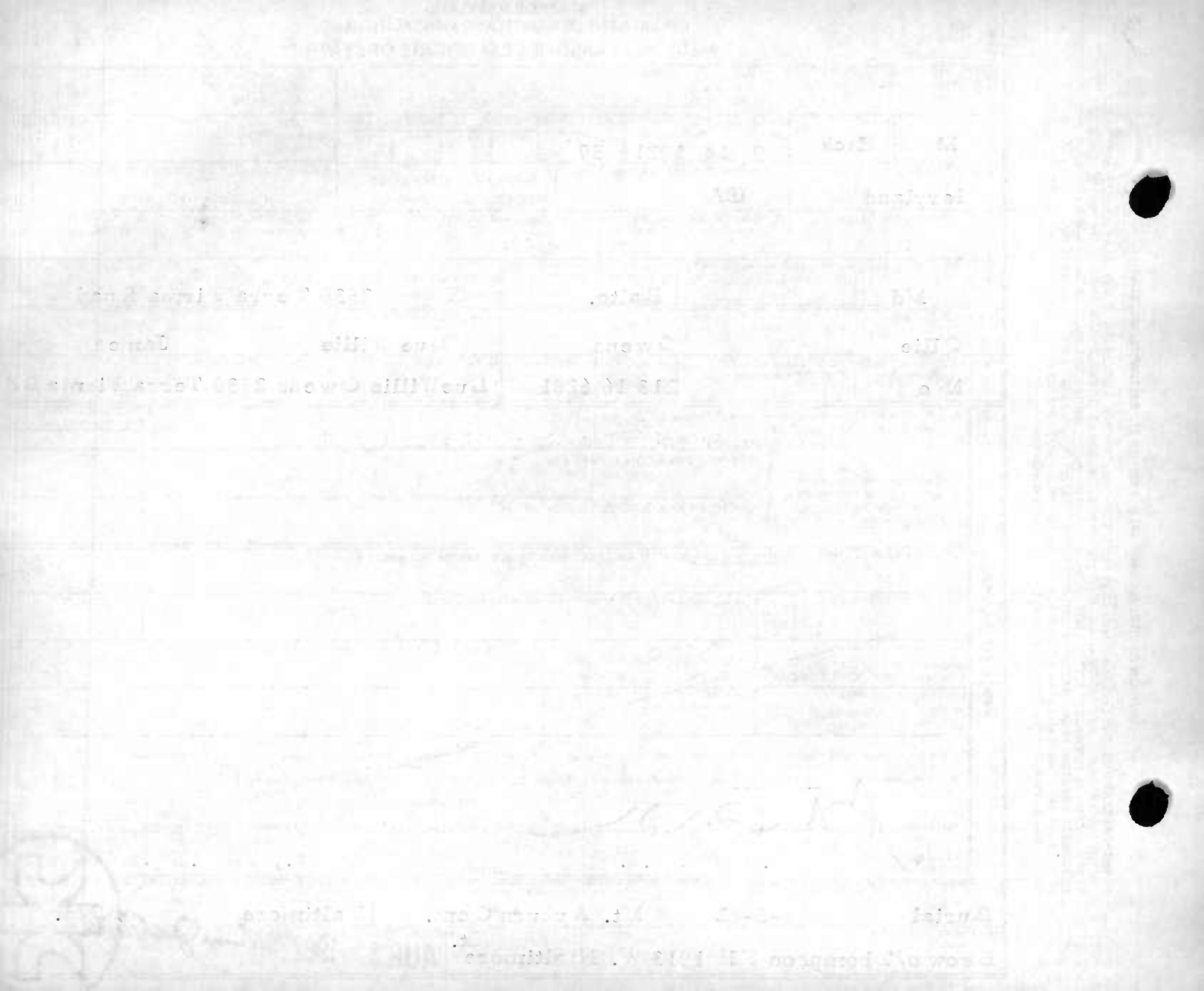
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |  |   |  |  |
|--|--|---|--|--|--|--|---|--|--|
| 1- FOR STATE REGISTRAR <b>EDWARD CLIFTON OVERINGTON</b> <b>CERTIFICATE OF DEATH</b> REG. NO. <b>82 20743</b>   |  |   |  |  |  |  |   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>OVERINGTON</b>   |  |   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>8 24 82</b>  |  | 2b HOUR<br><b>6:31 P.M.</b>   |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>8 24 82</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>18 11</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City MD.</b>  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hosp.</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b KIND OF BUSINESS OR INDUSTRY         |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br><b>Maryland Dorchester</b>   |  |   |  |  | 13b INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13c STREET ADDRESS<br><b>Poplar Street</b>  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Edward Warren Clifton Overington</b>  |  |   |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Cheryl Lynn Phillips</b>                       |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS<br><b>Edward Warren Clifton Overington, Hurlock, Md. 21643</b>  |  |  |   |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>7589 IMMEDIATE CAUSE (a) Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chromosomal Abnormality</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Prematurity</b>                                    |  |   |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |   |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a I certify that (1) (this hospital) attended the deceased from <b>8/24 19 82</b> to <b>8/24 19 82</b> , that (1) (we) lost saw the deceased alive on <b>8/24 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. |  |   |  |  |  |  |   |  |  |
| 22b SIGNATURE<br><b>Steven Grossman</b>  |  |   |  | DEGREE<br><b>MO</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c DATE SIGNED<br><b>8/24/82</b>        |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN GROSSMAN</b>   |  |   |  | 22e ADDRESS<br><b>Baltimore City Hospital</b>  |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>Aug. 28, 1982</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Junior Order Cemetery</b>  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Preston, Caroline, Maryland</b>   |   |  |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Frampton-u</b>  |  |   |  | ADDRESS<br><b>Federalburg</b>  |  | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE<br><b>AUG 30 1982</b>   |   |  |  |
| 26 HOME OF DECEASED<br><b>Home, 216 N. Main St.</b>  |  |   |  |  |  |  |   |  |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |               |  |   |  |  |  |  |  | REG. NO. 20744  |  |
|--|--|---------------|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |               |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JESSE OWENS   |  |               |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 8 1 1982 |  |
| 3. SEX M   |  | 4. RACE Black |  | 5. DATE OF BIRTH MONTH DAY YEAR 9 14 1923   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.  |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 1 1982                                 |  | 2b. HOUR a M 8:20   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                          |  |   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |               |  |   |  |  |  |  |  |   |  |
| 13a. STATE Md  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Balto.  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 2530 Terra Firma Road  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ollie Owens  |  |               |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lue Willie James   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No  |  |               |  | 16b. SOCIAL SECURITY NO. 213 16 6281  |  | 17. INFORMANT ADDRESS Lue Willie Owens 2530 Terra Firma Rd                                   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |               |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |               |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE   |  |               |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER   |  |  |  | DATE SIGNED 8-1-82   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.   |  |               |  | ADDRESS 111 Penn St., Balto., Md. 21201   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |               |  | 23b. DATE 8-5-82  |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.                            |  |   |  |
| 24. FUNERAL DIRECTOR NAME B row n/Thompson F H   |  |               |  | ADDRESS 1913 W. N Baltimore   |  | 25a. DATE REC'D. BY REGISTRAR AUG 3 1982   |  | 25b. REGISTRAR'S NAME  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|---|--|
| FOR Item 13 b&c Phone<br>1- STATE 8-25-82 cn<br>REGISTRAR  |  |  |  |   | 7 2 2 0 7 4 5<br>REG. NO.  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Pailin, BABY GIRL   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>7/16/82  |  |  | 2b. HOUR<br>16 <sup>03</sup> M         |   |  |
| 3. SEX<br>F  |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 6 82  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>0 YRS                                   |  | # UNDER 1 YEAR<br>MONTHS DAYS<br>1 10  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                 |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALT. CITY HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>INFANT |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>- |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE  |  |  |  |   | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>1828 Prestman St Baltimore 21217 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DOROTHEA PAILIN   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>-  |  | 17. INFORMANT<br>-  |  | ADDRESS  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>7684 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) BRADY CARDIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 MIN.                    |  |  |  |   |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>SEPSIS, PREMATURITY   |  |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>NONE   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 6, 19 82, to July 16, 19 82, that (I) (we) lost<br>saw the deceased alive on July 16, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Yvonne Maldonado MD  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>7/17/82            |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>YVONNE MALDONADO  |  |  |  |   | 22e. ADDRESS<br>5563 GULF STREAM RD COL, MD  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTO CITY HOSP   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD                     |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |  |  |   | 25a. DATE OF DEATH<br>AUG 19 1982  |  |  |  |   |  |

Item 17 Pen Phone  
8-52-85 cm

With Phone  
8-52-85 cm

1917  
1858 Treatment of Baltimore

AUG 2 1917



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 4 6

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CARMELA PALATUCCI</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 / 8 / 82</b>                          |  | 2b. HOUR<br><b>7:43 AM</b>   |
| 3 SEX<br><b>F</b>  | 4. RACE<br><b>W</b>                        | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 5 86</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS.                                     | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ITALY</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b>                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>    | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>M.D.</b>  |  |   | 13b. CITY OR TOWN<br><b>Balt.</b>  | 13c. STREET ADDRESS<br><b>1925 QUEENSWAY</b>   | 21222  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Salvatore Cione</b>  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Vincenza Pizziusso</b>        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219.32.0900</b>  |  | 17. INFORMANT ADDRESS<br><b>Carmella Uttenreither (Same as 13c)</b>                  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio. pulmonary arrest</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Bedridden after fractured pelvis 5 wks. prior to death</b>  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Stephen D. Campbell, M.D.</b>   |  |   | DEGREE<br><b>M.D.</b>  | 22c. DATE SIGNED<br><b>8/8/1982</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen D. Campbell, M.D.</b>  |  |   | 22e. ADDRESS<br><b>Mercy Hospital, Baltimore, Md.</b>                          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>8/11/1982</b>              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat'l. Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Maryland</b>       |  |
| 24. FUNERAL DIRECTOR<br><b>Walter Brooks Bradley, Inc., Dundalk, Md. 21222</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 9 1982</b>                             | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                  |  |

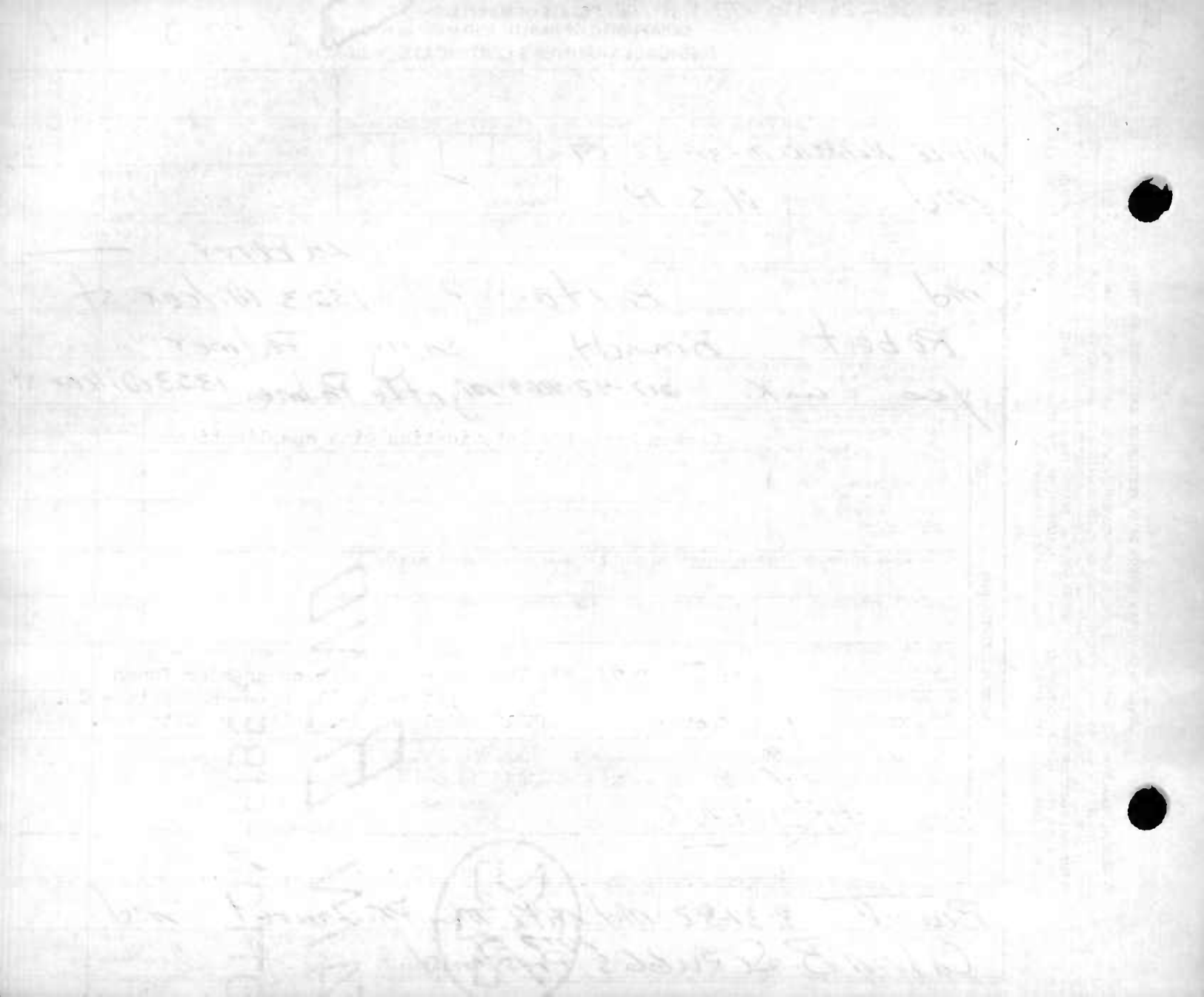


|  |  |   |   |   |
|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Bernard Palmer</b>   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>8 26 1982</b>   |   | 2b. HOUR<br>M<br><b>4:AM</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>NEGROID</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-31-22</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59 YRS.</b>   | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>laborer</b>   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>MD.</b>   | 13b. COUNTY<br><b>BALTO.</b>   | 13c. CITY OR TOWN<br><b>BALTO.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1323 Wilcox st</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Brandt</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sally Palmer</b>  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>unk.</b>   | 17. INFORMANT<br>ADDRESS<br><b>Myrtle Palmer 1323 Wilcox st</b>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carbon Monoxide Intoxication with complications</b><br>8688<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY<br>HOUR <del>AM</del> MONTH DAY YEAR<br><b>3: P.M. 7/7/ 1982</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Inhaled gas engine compressor fumes</b>                                 |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>factory</b>  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>5215 Fairlawn Ave. Baltimore City Md.</b>   |   |   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |   |   |   |
| ACTUAL SIGNATURE<br><b>H.R. Guard</b>  |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER   |   | DATE SIGNED<br><b>8/27/82</b>   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |  | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   | 23b. DATE<br><b>8-31-82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. Natl. Mem. Pk.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel MD.</b>                                 |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Calvin B. SCRUBBS</b>   |  | ADDRESS<br><b>1412 E. Preston St.</b>   | 25a. DATE REC'D. BY REGISTRAR<br><b>8/26/1982</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                 |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

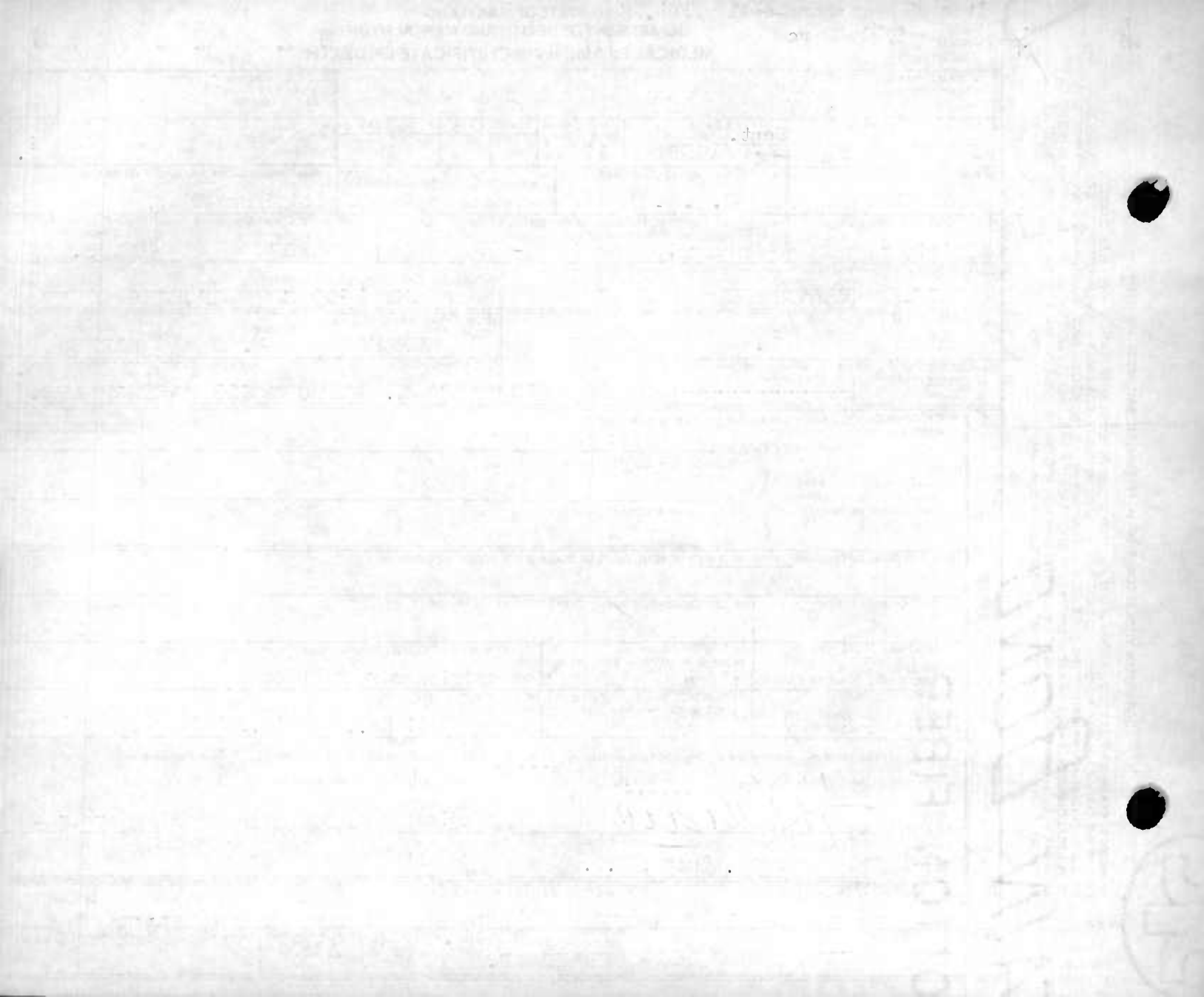
0909 BP DHMH - 17 (VR A15 ME (1)) 20M 4/82

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Item #5 per phone call w/Fun. HomeState of MARYLAND  |  |                  |  |  |  |  |  |   |  | 8 2   |  | 2 0 7 4 8  |  |
|--|--|------------------|--|--|--|--|--|---|--|---|--|--|--|
| FOR STATE REGISTRAR 9/21/82 rc   |  |                  |  |  |  |  |  |   |  | REG. NO.  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Deborah ANN Palughi  |  |                  |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>8 28 1982 |  | 2b. HOUR<br>M<br>P.M.  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH DAY MONTH YEAR<br>Sept. 8 26 1959   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>22 |  | 7. IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>8 28 1982  |  | 2d. HOUR<br>1:45 P.M.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  |                  |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                     |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital - STU |  |  |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LABOR   |  |   |  | 15. KIND OF BUSINESS OR INDUSTRY<br>BALTO. CITY                                  |  |
| 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE  |  |                  |  |  |  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 13e. STREET ADDRESS<br>1609 FOUR GEORGES COURT                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MARCO L. PALUGHI  |  |                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELEANOR A. KARES   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO   |  |   |  | 16b. SOCIAL SECURITY NO. 220 80 0622   |  |
| 17. INFORMANT ADDRESS<br>MARCO L. PALUGHI 823 EASTERN AVE.   |  |                  |  |  |  |  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8147 IMMEDIATE CAUSE (a) Multiple Injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |                  |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>2:10 PM 8 28 1982  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10 PART 1 OR PART 2)<br>pedestrian struck by auto  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>German Hill Rd., Dundalk, Baltimore, Maryland   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <i>ARSuaw</i>   |  |                  |  | TITLE (SPECIFY) Assistant  |  |  |  | DATE SIGNED 8-29-82   |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.  |  |                  |  | ADDRESS 111 Penn Street  |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  |                  |  | 23b. DATE 9/1/1982   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY MOST HOLY REDEEMER   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                    |  |
| 24. FUNERAL DIRECTOR DIPPEL FUNERAL HOMES  |  |                  |  | ADDRESS 7110 BELAIR RD.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR SEP 2 1982  |  |   |  | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>                                    |  |





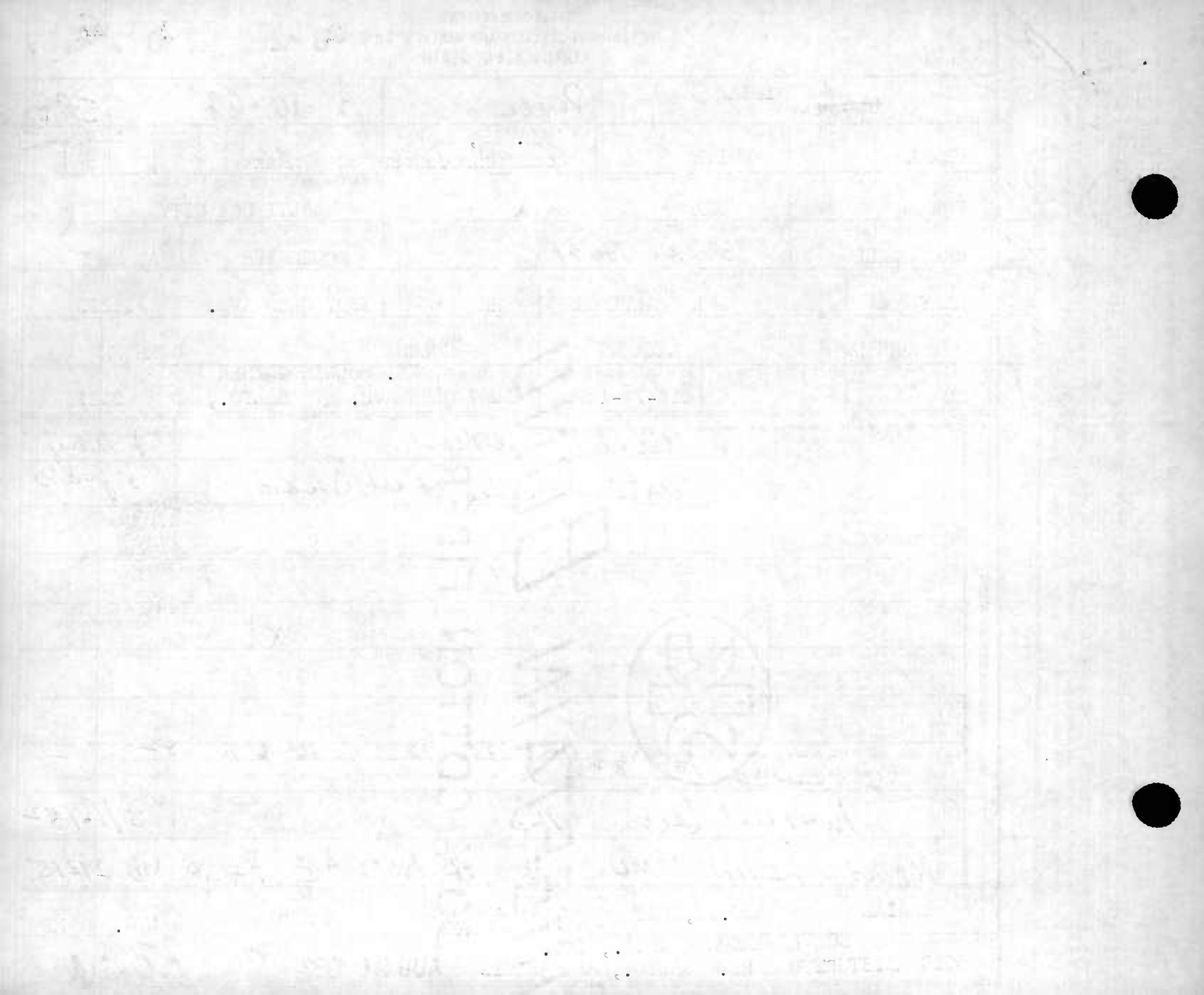
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 0 7 4 9<br>REG. NO.   |  |  |  |  |  |   |  |                          |  |  |  |
|---|--|--|--|---|--|--|--|--|--|---|--|--------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 1. DECEASED NAME (TYPE OR PRINT) <b>MIRIAM</b> FIRST MIDDLE LAST <b>PALMER</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>8-16-82</b>  |  |   |  | 2b. HOUR <b>507 P.M.</b> |  |  |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 15, 1900</b><br><b>XXXXXX XXXX XXXX</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> <b>82</b> YRS.                       |  | 7. UNDER 1 YEAR MONTHS DAYS  |  | 7. UNDER 24 HRS. HOURS MIN.   |  |                          |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                 |  |  |  |   |  |                          |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSP</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b> |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  |  |                          |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3907 GLEN AVE.</b> #21215  |  |                          |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>KOPPEL LAZARUS</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MOLCHA UNKNOWN</b>  |  |  |  |  |  |   |  |                          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>214-74-1199</b>   |  | 17. INFORMANT <b>MRS. MOLLIE GRINER</b>  |  |  |  | 3907 GLEN AVE. BALTO., MD 21215   |  |                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>none</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>5 years</b>  |  |                          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>none</b>  |  |  |  |   |  |  |  |  |  |   |  |                          |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |  |                          |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                          |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 30, 1982</b> to <b>Aug 16, 1982</b> , that (I) (we) last saw the deceased alive on <b>Aug. 16, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |   |  |                          |  |  |  |
| 22b. SIGNATURE <b>Manuel Levin</b> DEGREE <b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED <b>8/16/82</b>  |  |   |  |                          |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MANUEL LEVIN MD</b>  |  |  |  | 22e. ADDRESS <b>6101 PK HOTS AVE BALTO MD 21215</b>   |  |  |  |  |  |   |  |                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  |  | 23b. DATE <b>AUG. 17, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>SHOMREI MISHMERES SCHARITH HAPLATA</b>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>   |  |                          |  |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 20 1982</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Griner</b>   |  |   |  |                          |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  |   |  |  |  |  |  |   |  |                          |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 2 20750

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY C LAST PANELLA                            |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>08/21/82   |  | 2b. HOUR<br>11:28a  |
| 3. SEX<br>Female  | 4. RACE<br>White                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 24, 1924  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Conn.                                       | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                      |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL                         |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House Wife | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |  |   |
| 13a. STATE<br>Md.   | 13b. COUNTY<br>Balto.                    | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>432 Academy Rd.   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William R. Carver                                 |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances Egles                                  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>1159 Granville Rd. Balto. Md. 21207<br>Mr. Richard C. Panella |   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>minutes |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>acute myocardial infarction</u>   |  | day  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic coronary disease</u>   |  | years.   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOT BY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/16/1982 to 8/21/1982, that (I) (we) lost<br>saw the deceased alive on 8/21/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (do) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>John Mannisi</u> MD   | DEGREE   | 22c. DATE SIGNED<br>8/21/82  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Mannisi MD   |  | 22e. ADDRESS<br>600 N. WOLFE STREET BALT.  |  |

|  |                            |   |  |
|--|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                | 23b. DATE<br>Aug. 24, 1982 | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Cem. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. |
| 24. FUNERAL DIRECTOR<br>NAME G. THUMAN SCHWAB ADDRESS<br>5151 BALTO. NATIONAL PIKE 21229 |                            | 25a. DATE REC'D BY REGISTRAR<br>AUG 30 1982         | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver             |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

| FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 2 20751                  |  |  |  |
|--|--|---|--|--|--|---|--|----------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR                   |  |  |  |
| CARRIE E Parks   |  |   |  | 8-19-82  |  |   |  | 6:30 P M                   |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  | IF UNDER 1 YEAR            |  | IF UNDER 24 HRS.                             |  |
| FEMALE   |  | White   |  | 12-31-12   |  | 69 YRS.   |  | MONTHS                     |  | DAYS   |  |
| 7a. BIRTHPLACE   |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                            |  |  |  |
| West Virginia  |  | U.S.A.  |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | Baltimore City MD.  |  |                            |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  |  |  |   |  | 12a. USUAL OCCUPATION      |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore  |  | John L. Deaton Med. Center                              |  |  |  |   |  | Housewife                  |  | Home   |  |
| 13a. STATE   |  |   |  | 13b. CITY OR TOWN  |  |   |  | 13c. STREET ADDRESS        |  |  |  |
| Md.  |  |   |  | Pasadena   |  |   |  | 8156 Solley Road           |  |  |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |                            |  |  |  |
| Benjamin Nelson  |  |   |  | Elisa Jane SELF  |  |   |  |                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |   |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT              |  |  |  |
| Unknown  |  |   |  | 218-42-00705   |  |   |  | Nancy Youngbar, same as 13 |  |  |  |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |   |  |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4275 IMMEDIATE CAUSE (a) CARDIAC ARREST  |  |   |  |  |  |   |  |                            |  | none   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  |                            |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |  |  |  |   |  |                            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  |                            |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:   |  |   |  |  |  |   |  |                            |  |  |  |
| Cerebral infarction with triglycerin   |  |   |  |  |  |   |  |                            |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? |  |                            |  |  |  |
|  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED   |  |   |  |                            |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR                                |  | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |                            |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION  |  |   |  |                            |  |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | STREET   |  | CITY OR TOWN  |  | COUNTY                     |  | STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from November 11, 1982, to August 19, 1982, that (I) (we) last saw the deceased alive on August 19, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |  |  |  |   |  |                            |  |  |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |  |   |  | 22c. DATE SIGNED           |  |  |  |
| DAMIAN E. BIRCHES  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 8/19/82                    |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |   |  |                            |  |  |  |
| DAMIAN E. BIRCHES  |  |   |  | 105 FURNLEE DRIVE  |  |   |  |                            |  |  |  |
|  |  |   |  | GLEN BURNIE, MD. 21061   |  |   |  |                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |                            |  |  |  |
| Burial   |  | 8/24/1982   |  | Glen Haven Mem. Park   |  | Glen Burnie Anne Arundel Co. Md.                              |  |                            |  |  |  |
| 24. FUNERAL DIRECTOR   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |
| Mc Cully F.H. Mountain & Tick Neck Rds. 27722  |  |   |  | AUG 25 1982  |  |   |  | John J. Gault              |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| VALERIE  |  | PARKS  |  | 8/28/82   |  | 8/28/82   |  | 9:10 PM                                      |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS                              |  |
| F Female   | W. White   | Oct. 7, 1920   |  | 61 YRS  |  | MONTHS DAYS   |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| Czechoslovakia   | U.S.A.   |  |  | Baltimore City MD   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Baltimore  | Good Samaritan Hospital  |  |  | Housewife   |  |   |  |  |  |
| 13a. STATE   |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS   |  | 13d. INSIDE CITY LIMITS?  |  |  |  |
| Maryland   |  | Baltimore  |  | Parkville   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 8 Palma Court 21234                          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |  |   |  |  |  |
| Not Known  |  | Vogel  |  | Not Known   |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |  |  |
| No   |  | 217-34-9739  |  | Mr. Ostap Sadowyj 8 Palma Court 21234   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4960 COR PULMONALE</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD NEW ONSET ATRIAL FB</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>KOPD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Diabetes mellitus</u>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                |  |   |  |  |  |
|  |  | P.M. 19  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
|  |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/24/82</u> to <u>8/28/82</u> that (I) (we) lost saw the deceased alive on <u>8/28/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE MD  |  | House Staff   |  | 22c. DATE SIGNED  |  |  |  |
| B Nagpal   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 8/28/82   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |  |  |
| B. NAGPAL  |  | E.S. Hosp. Baltimore MD  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | 23e. COUNTY STATE                            |  |
| Burial   |  | Sept 1 1982  |  | Parkwood Cemetery   |  | Baltimore   |  | Maryland                                     |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Leonard J. Ruck, Inc. Baltimore, Maryland  |  |  |  | AUG 30 1982   |  | John J. Givier  |  |  |  |



WHITE

PARK

at

Oct. 7, 1932

White

F. P. Jones

Albion City

x

W. A. A.

Greenleaf

Housewife

Good American Household

Albion

1932

Albion County

x

Albion

Albion

Albion

Not Known

Legal

Not Known

Albion County, 1932

1932-1933

No

FOR INFORMATION

ALBION COUNTY

1932-1933

ALBION COUNTY

1932-1933

1932-1933

1932-1933

Albion County

1932

1932-1933

1932-1933

Albion

Albion

Albion County

1932-1933

Albion

Albion County

Albion County, 1932-1933

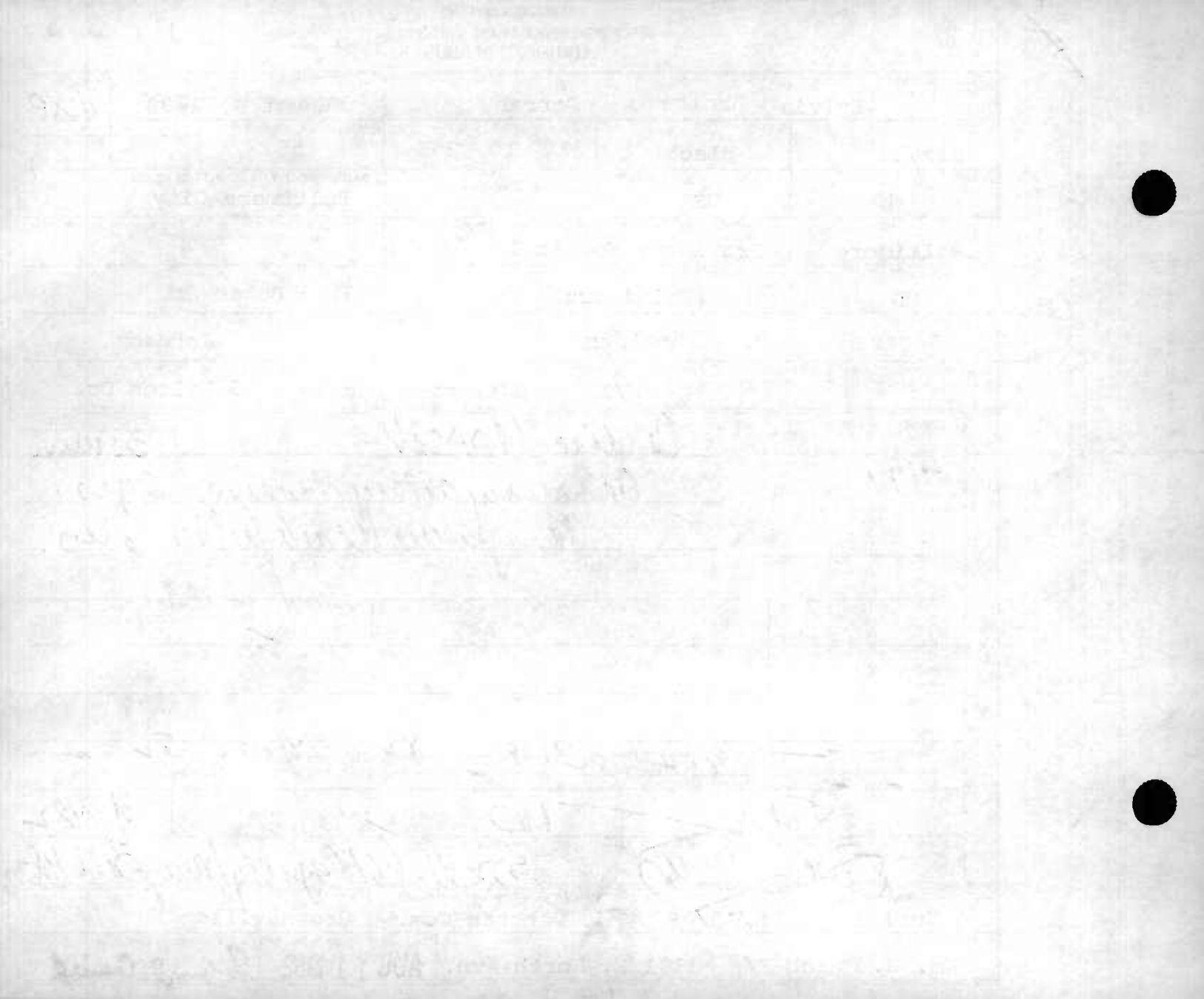


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

| FOR<br>1. STATE<br>REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | REG. NO.<br>8 2 2 0 7 5 3   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Sylvia Arnita Parran  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>August 9, 1982   |  | 2b. HOUR<br>4:25 PM   |  |
| 3. SEX<br>Female   | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 10 26   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55<br>YRS. MONTHS DAYS                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY                      |
| 13a. STATE<br>MD   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Rogers C. Moulden  |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>Clara Johnson  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT ADDRESS<br>Catherine Burris 6635 Dalton Dr.                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive heart failure</u><br>6 yrs. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 min |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>6 yrs</u>  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>8/4</u> 19 <u>82</u> to <u>8/10</u> 19 <u>82</u> , that <u>we</u> (we) lost <u>saw</u> the deceased alive on <u>8/4</u> 19 <u>82</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>we</u> (we) (did not) view the body after death.  |   |   |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |   | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>8/10/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>[Signature]</u>  |   | 22e. ADDRESS<br><u>522 W. Cold Spring Lane, Bell, Md 20601</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>8/13/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem.  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD   |   |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |   | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 11 1982  |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  | REG. NO. 8 2 2 0 7 5 4   |  |   |  |  |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a DATE OF DEATH MONTH DAY YEAR  |  | 2b HOUR                                      |  |
| Clarence  |  | Patterson  |  |   |  |  |  | 8-2-82   |  | 3:40 P.M.                                    |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN                    |  |
| Male  |  | Black  |  | 7 15 11   |  | 71   |  |  |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |
| Maryland  |  | USA  |  |   |  | Baltimore City MD.   |  |  |  |  |  |
| 11 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY             |  |
| Baito, Md   |  | Lutheran Hospital  |  |   |  |  |  |  |  |  |  |
| 13a STATE   |  | 13b COUNTY   |  | 13c CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS   |  |  |  |
| MD  |  |  |  | Baltimore   |  |  |  | 3114 Presbury St.  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |
| Giles Patterson   |  |  |  | Cora Bluford  |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS  |  |  |  |  |  |  |  |
| No  |  | N/A  |  | William A. Patterson 1218 N. Montford   |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordae arrest</u>  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA, R/myocardial infarction</u>   |  |  |  |   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |  |   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>S. Suwanapool</u>   |  |  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 8/2/82                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. SUWANAPOL, MD</u>   |  |  |  | 22e. ADDRESS <u>Lutheran Hospital, MD</u>   |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>  |  | 23b. DATE <u>8/7/82</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Mt. Zion Md.</u>                                  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H 1101 E. North Avenue</u>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <u>AUG - 5 1982</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

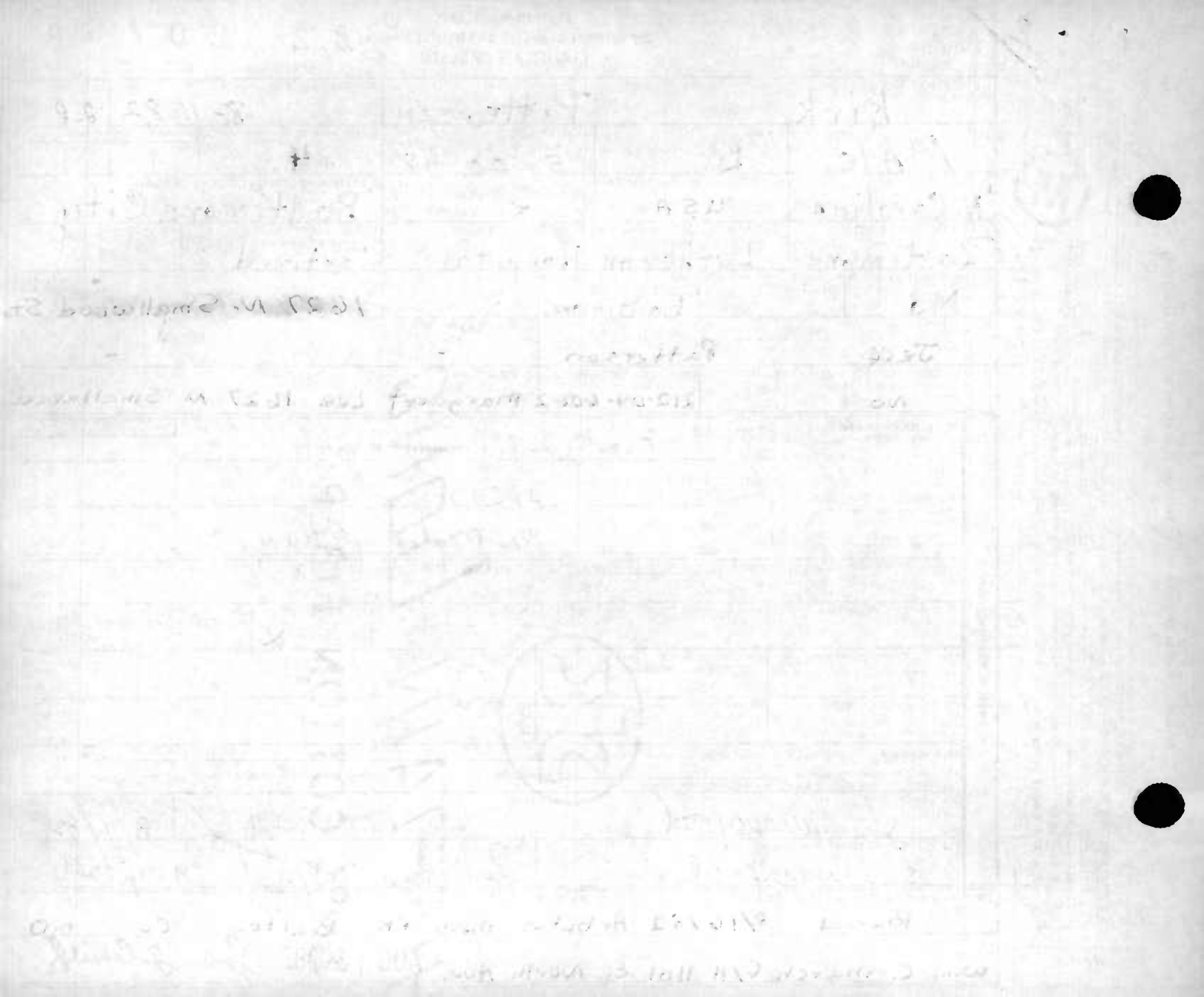
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 states any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 10-50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Kirk</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>8-11-82</b>  |  |
| 3. SEX <b>Male</b>  |  | 2b. HOUR <b>2 P M</b>  |  |
| 4. RACE <b>B.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR <b>5 20 98</b>  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>                          |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>Md</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  |
| 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS <b>1627 N. Smallwood St.</b>  |  | 13f. STREET ADDRESS <b>1627 N. Smallwood St.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Jeff Patterson</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>-</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>212-09-6062</b>  |  |
| 17. INFORMANT ADDRESS <b>Margaret Lee 1627 N. Smallwood</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCUD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Respiratory failure, CVA</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>a</b>   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |
| 22b. SIGNATURE <b>S. Swanapool</b>  |  | 22c. DATE SIGNED <b>8/11/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Swanapool</b>   |  | 22e. ADDRESS <b>Lutheran Hospital, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>8/16/82</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus mem. Pk</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Co. MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1982</b>   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Lohr</b>   |  |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 5 6

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br><b>ROLAND PATTERSON</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>AUG 9, 1982</b>   |  | 2b. HOUR<br><b>1:45 P.M.</b>  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>9 - 22 - 28</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT CITY</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO. MD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>EDUCATOR</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SCHOOL SYSTEM</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter F. Patterson</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georgia Conyers</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-30-9998</b>  |  |
| 17 INFORMANT<br><b>Mrs. Marion Patterson</b>   |  | ADDRESS<br><b>Same</b>   |  | 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas with metastases</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                     |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>X</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>X</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>X</b><br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>X</b>   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>X</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>X</b>  |  | 22a. I certify that (this hospital) attended the deceased from <b>8/3/82</b> to <b>8/9/82</b> , that (we) lost<br>saw the deceased alive on <b>8/9/82</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. |  |
| 22b. SIGNATURE<br><b>Dr. Mack Bonner Jr.</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br><b>8/9/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MACK BONNER, JR.</b>   |  | 22e. ADDRESS<br><b>2600 LIBERTY HTS, BALTO, MD.</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   |  |
| 23b. DATE<br><b>8-20-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md. Baltimore Md.</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>AUG 10 1982</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James H. Morton &amp; Sons</b>  |  | ADDRESS<br><b>1701 Lombard St.</b>   |  | REGISTRAR'S SIGNATURE<br><b>Joan J. Carver</b>   |  |   |  |

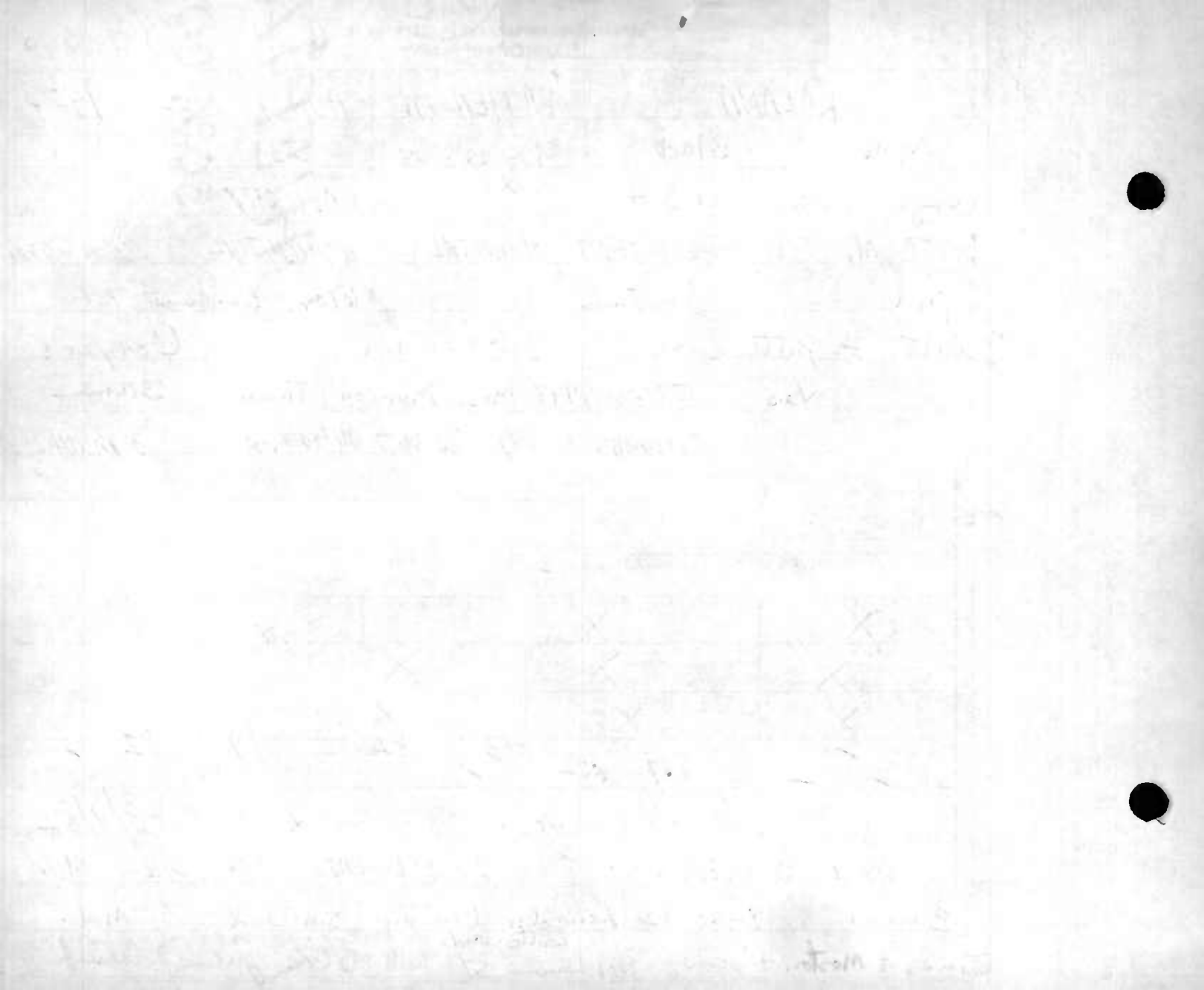
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without page 3 after death.

IMPORTANT: If item 21 is marked or item 18 is any injury, or other traumatic event, the medical examiner should be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 0 7 5 7<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FLORENCE DORIS PAUL   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 20 1982  |  | 2b. HOUR<br>8PM M  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 9, 1926  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL OF BALTO. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13b. STREET ADDRESS<br>7513 LABYRINTH RD. #21208   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DANIEL DAVID RAPHAEL   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA GOLDBERG   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>134-14-5473   |  | 17. INFORMANT MR. NORMAN PAUL ADDRESS<br>7513 LABYRINTH RD. #21208   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>1749 IMMEDIATE CAUSE (a) widespread bone, pulmonary, carcinoma metastatic<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CA of the breast<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 1/2 years<br>5 years |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 16  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/20, 1982, to 9/20, 1982, that (I) (we) lost saw the deceased alive on 8/20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Lm   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>8/20/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lm  |  |   |  | 22e. ADDRESS<br>SINAI HOSP OF BALTO, MD, 21215  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>8-22-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SHAAREI TFILOH  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD   |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 24 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John G. Canfield   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |  |  | 8 2 2 0 7 5 8  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  |  |   |  |  |  | REG. NO.   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lottie E. PAUL</b>   |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>August 6, 1982</b>                       |  | 2b. HOUR<br><b>10:59P M</b>  |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 24 1904</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Own Home</b> |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Edgemere</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Harry Donton</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma Stutzman</b>   |  | 13e. STREET ADDRESS<br><b>2919 Salisbury Avenue</b>                             |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-22-7948</b>   |  | 17 INFORMANT<br><b>Donald O. Paul</b>   |  | ADDRESS<br><b>2913 Salisbury Ave. Balto. MD 21219</b>  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>2387</b> IMMEDIATE CAUSE (a) <b>Probable Intracerebral Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myeloproliferative Disorder</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Atherosclerotic Cardiovascular Disease, Congestive Heart Failure, Anemia</b>   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <b>XX</b> (this hospital) attended the deceased from <b>July 16</b> , 19 <b>82</b> , to <b>August 6</b> , 19 <b>82</b> , <b>XX</b> saw the deceased alive on <b>August 6</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <b>X</b> (we) (did) <b>XXXX</b> view the body after death.                       |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Joseph Nkwanyuo</b> MD   |  |  |  |  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/7/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH A. NKWANYUO</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>MGH</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>8/10/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter's Lutheran</b>               |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Orwin Pennsylvania</b>   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Duda-Ruck, Inc.</b>  |  |  |  |  |  | ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 10 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 20759

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDITH S. PAWL   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 9 82   |   | 2b. HOUR<br>730 P.M.  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 30 14   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.                                    | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cook                        | 12b. KIND OF BUSINESS OR INDUSTRY<br>Resturant                                |   |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>A.A. Co.   | 13c. CITY OR TOWN<br>Brooklyn Pk.   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>311 W. 4th Avenue 21225                                |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William J. Saunders  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha J. Toney  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>216-12-2365   |   | 17. INFORMANT ADDRESS<br>Clifford W. Pawl 311 4th Ave. 21225                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiogenic Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Acute Myocardial Infarction</u> |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-31 1982, to 8-9 1982, that (I) (we) last saw the deceased alive on 8-9 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.         |   |   |   |   |   |
| 22b. SIGNATURE<br>Michael B. Nestor  |   | DEGREE<br>MD.   |   | 22c. DATE SIGNED<br>8-9-82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael B. Nestor   |   | 22e. ADDRESS<br>3001 S. Hanover St, Balt.   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>8/13/82  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk,                                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.   |   | ADDRESS<br>21229 4107 Wilkens Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 13 1982                                  |   |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |   |   |   |   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

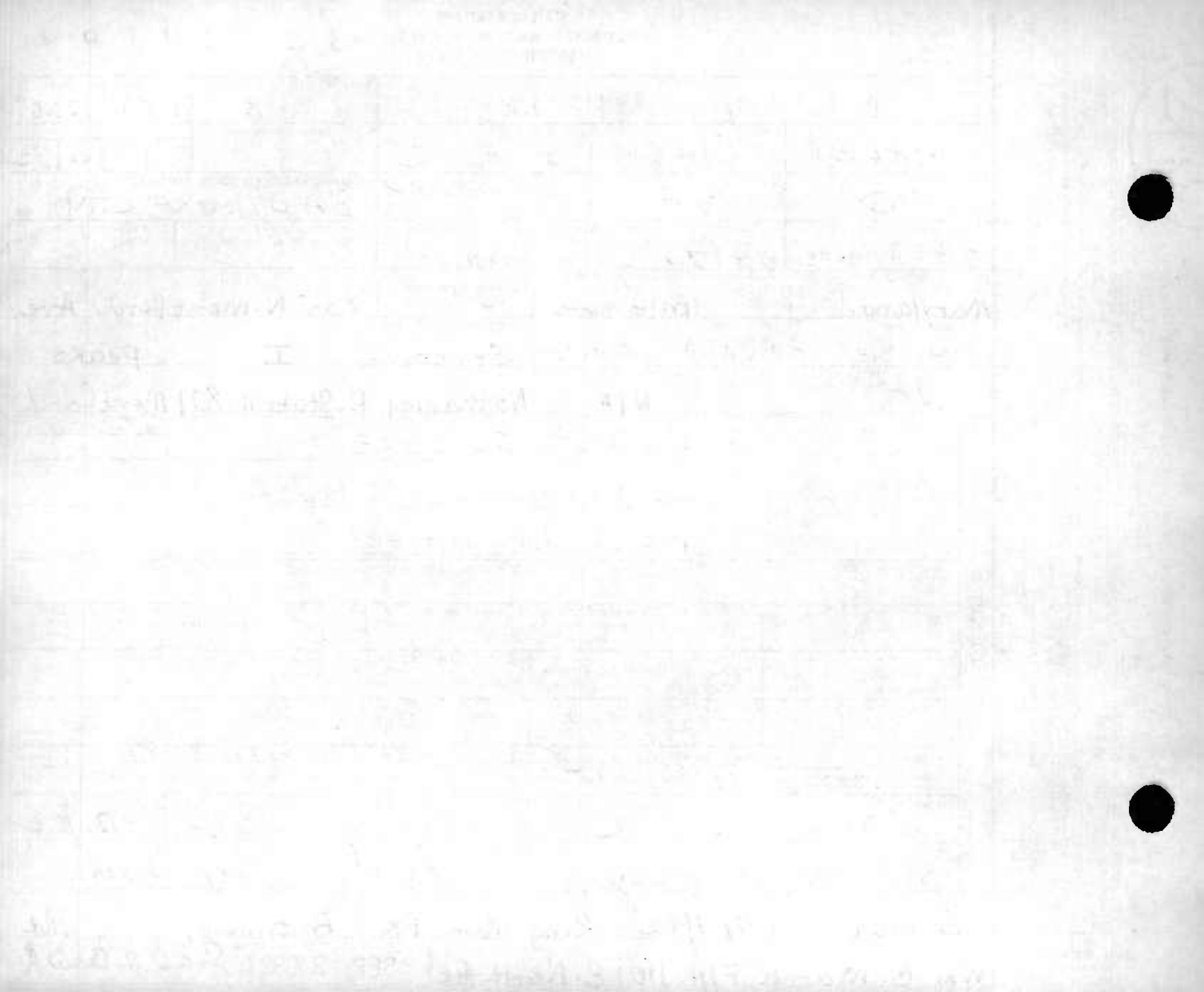
DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 20760

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 8 31 82   |  | 12:06 PM  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| MALE  |  | BLACK   |  | MONTH DAY YEAR  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| MD  |  | USA   |  |   |  | BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| BALTIMORE   |  | BALTO City Hosp.  |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13a. STATE  |  | 13b. CITY OR TOWN   |  | 13c. STREET ADDRESS   |  |
| Maryland  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 835 N. Montford Ave.  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |
| Willie EDWARD LONON   |  | Senobia I Peaks   |  | NO  |  | NIA.  |  |
| 17. INFORMANT   |  | 18. CAUSE OF DEATH  |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| Nathaniel R. Staten   |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) HEART FAILURE<br>7621<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Cardiovascular Collapse<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Placental bleed |  | 8/30 19 82  |  | 8/31 19 82  |  |
| ADDRESS   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 821 Montford  |  |   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |
|   |  |   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                  |  |
|   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
|   |  |   |  | 22a. I certify that (I) (this hospital) attended the deceased from 8/30 19 82, to 8/31 19 82, that (I) (we) last saw the deceased alive on 8/31 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Steuven Grossman  |  |
|   |  |   |  | 22c. DATE SIGNED<br>8/31/82   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |
|   |  |   |  | 22e. ADDRESS<br>Balto City Hosp.  |  | 22f. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22g. REGISTRAR'S SIGNATURE<br>John J. Carver  |  | 22h. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22i. DATE REC'D. BY REGISTRAR   |  | 22j. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22k. DATE REC'D. BY REGISTRAR   |  | 22l. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22m. DATE REC'D. BY REGISTRAR   |  | 22n. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22o. DATE REC'D. BY REGISTRAR   |  | 22p. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22q. DATE REC'D. BY REGISTRAR   |  | 22r. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22s. DATE REC'D. BY REGISTRAR   |  | 22t. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22u. DATE REC'D. BY REGISTRAR   |  | 22v. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22w. DATE REC'D. BY REGISTRAR   |  | 22x. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22y. DATE REC'D. BY REGISTRAR   |  | 22z. DATE REC'D. BY REGISTRAR   |  |
|   |  |   |  | 22aa. DATE REC'D. BY REGISTRAR  |  | 22ab. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22ac. DATE REC'D. BY REGISTRAR  |  | 22ad. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22ae. DATE REC'D. BY REGISTRAR  |  | 22af. DATE REC'D. BY REGISTRAR  |  |
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|   |  |   |  | 22ai. DATE REC'D. BY REGISTRAR  |  | 22aj. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22ak. DATE REC'D. BY REGISTRAR  |  | 22al. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22am. DATE REC'D. BY REGISTRAR  |  | 22an. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22ao. DATE REC'D. BY REGISTRAR  |  | 22ap. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22aq. DATE REC'D. BY REGISTRAR  |  | 22ar. DATE REC'D. BY REGISTRAR  |  |
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|   |  |   |  | 22ay. DATE REC'D. BY REGISTRAR  |  | 22az. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22ba. DATE REC'D. BY REGISTRAR  |  | 22bb. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22bc. DATE REC'D. BY REGISTRAR  |  | 22bd. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22be. DATE REC'D. BY REGISTRAR  |  | 22bf. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22bg. DATE REC'D. BY REGISTRAR  |  | 22bh. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22bi. DATE REC'D. BY REGISTRAR  |  | 22bj. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22bk. DATE REC'D. BY REGISTRAR  |  | 22bl. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22bm. DATE REC'D. BY REGISTRAR  |  | 22bn. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22bo. DATE REC'D. BY REGISTRAR  |  | 22bp. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22bq. DATE REC'D. BY REGISTRAR  |  | 22br. DATE REC'D. BY REGISTRAR  |  |
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|   |  |   |  | 22bu. DATE REC'D. BY REGISTRAR  |  | 22bv. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22bw. DATE REC'D. BY REGISTRAR  |  | 22bx. DATE REC'D. BY REGISTRAR  |  |
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|   |  |   |  | 22cc. DATE REC'D. BY REGISTRAR  |  | 22cd. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22ce. DATE REC'D. BY REGISTRAR  |  | 22cf. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22cg. DATE REC'D. BY REGISTRAR  |  | 22ch. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22ci. DATE REC'D. BY REGISTRAR  |  | 22cj. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22ck. DATE REC'D. BY REGISTRAR  |  | 22cl. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22cm. DATE REC'D. BY REGISTRAR  |  | 22cn. DATE REC'D. BY REGISTRAR  |  |
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|   |  |   |  | 22cq. DATE REC'D. BY REGISTRAR  |  | 22cr. DATE REC'D. BY REGISTRAR  |  |
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|   |  |   |  | 22cu. DATE REC'D. BY REGISTRAR  |  | 22cv. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22cw. DATE REC'D. BY REGISTRAR  |  | 22cx. DATE REC'D. BY REGISTRAR  |  |
|   |  |   |  | 22cy. DATE REC'D. BY REGISTRAR  |  | 22cz. DATE REC'D. BY REGISTRAR  |  |
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|   |  |   |  | 22dd. DATE REC'D. BY REGISTRAR  |  | 22de. DATE REC'D. BY REGISTRAR  |  |
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|   |  |   |  | 22dh. DATE REC'D. BY REGISTRAR  |  | 22di. DATE REC'D. BY REGISTRAR  |  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

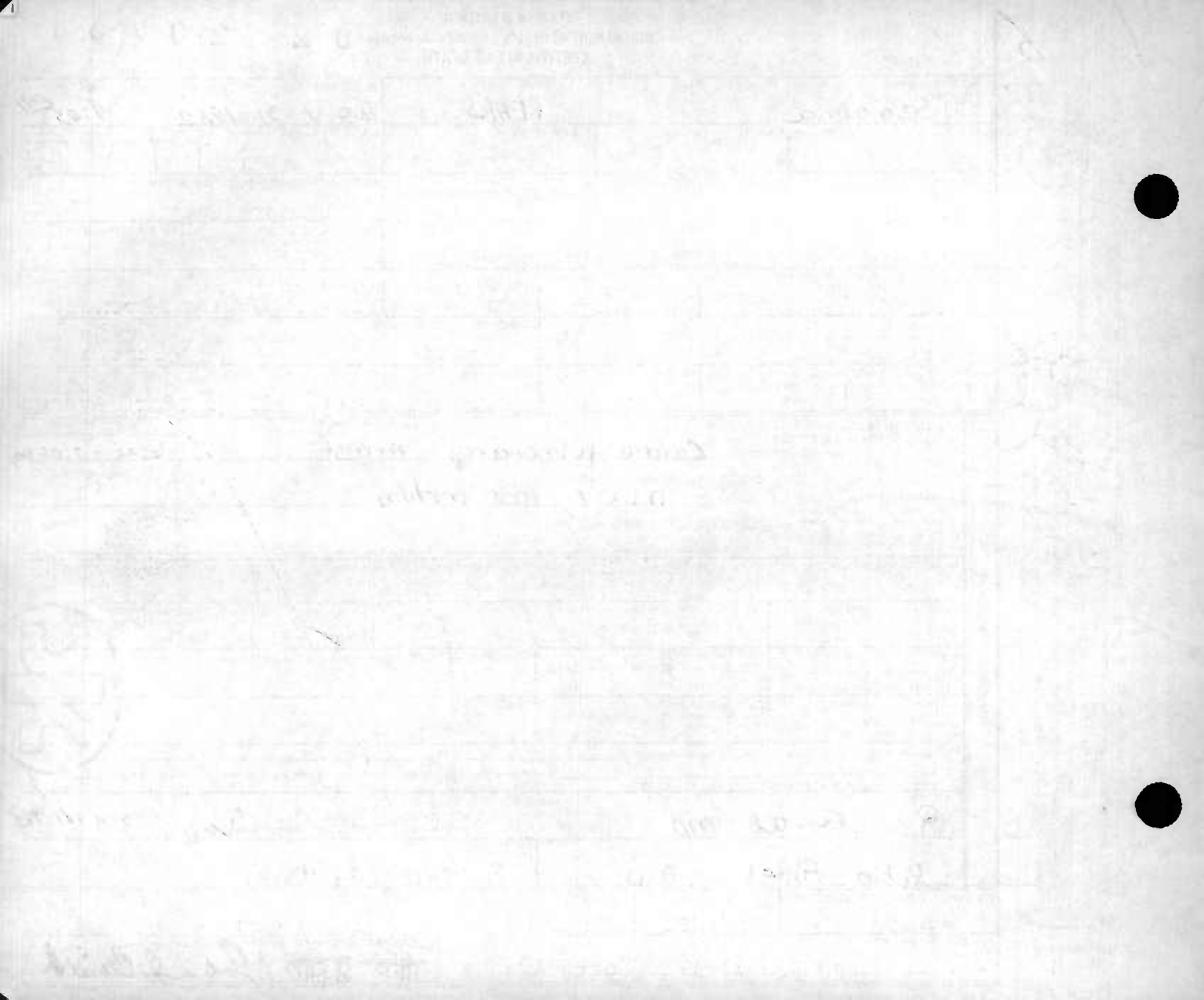
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |   |  |   |  |  |                                   |  |
|---|--|---|--|---|---|--|---|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Senobia I PEAKS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 31-1982</b>           |   | 2b. HOUR<br><b>7:05 PM</b>  |  |   |  |  |                                   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 27 61</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>21 YRS.</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |                                   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>835 N. Montford Avenue</b> |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur Peaks</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie Staten</b>  |   |   |  |   |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-88-2038</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Nathaniel Staten 821 Montford Avenue</b> |  |   |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b><br><b>2866</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DIC 1 post partum</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6:35 - 7:05 AM</b> |  |   |  |   |   |  |   |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |   |  |   |   |  |   |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |   |  |   |   |  |   |  |  |                                   |  |
| 22b. SIGNATURE<br><b>Robin Fintel MD</b>  |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>August 31/1982</b>            |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robin Fintel MD</b>   |  |   | 22e. ADDRESS<br><b>Baltimore City Hospital</b>                         |   |   |  |   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>9/1/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Pk.</b>              |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b>  |  |   |  |   |   | 25. DATE RECEIVED BY REGISTRAR<br><b>SEP 2 1982</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Joan J. Crain</b>  |  |                                   |  |

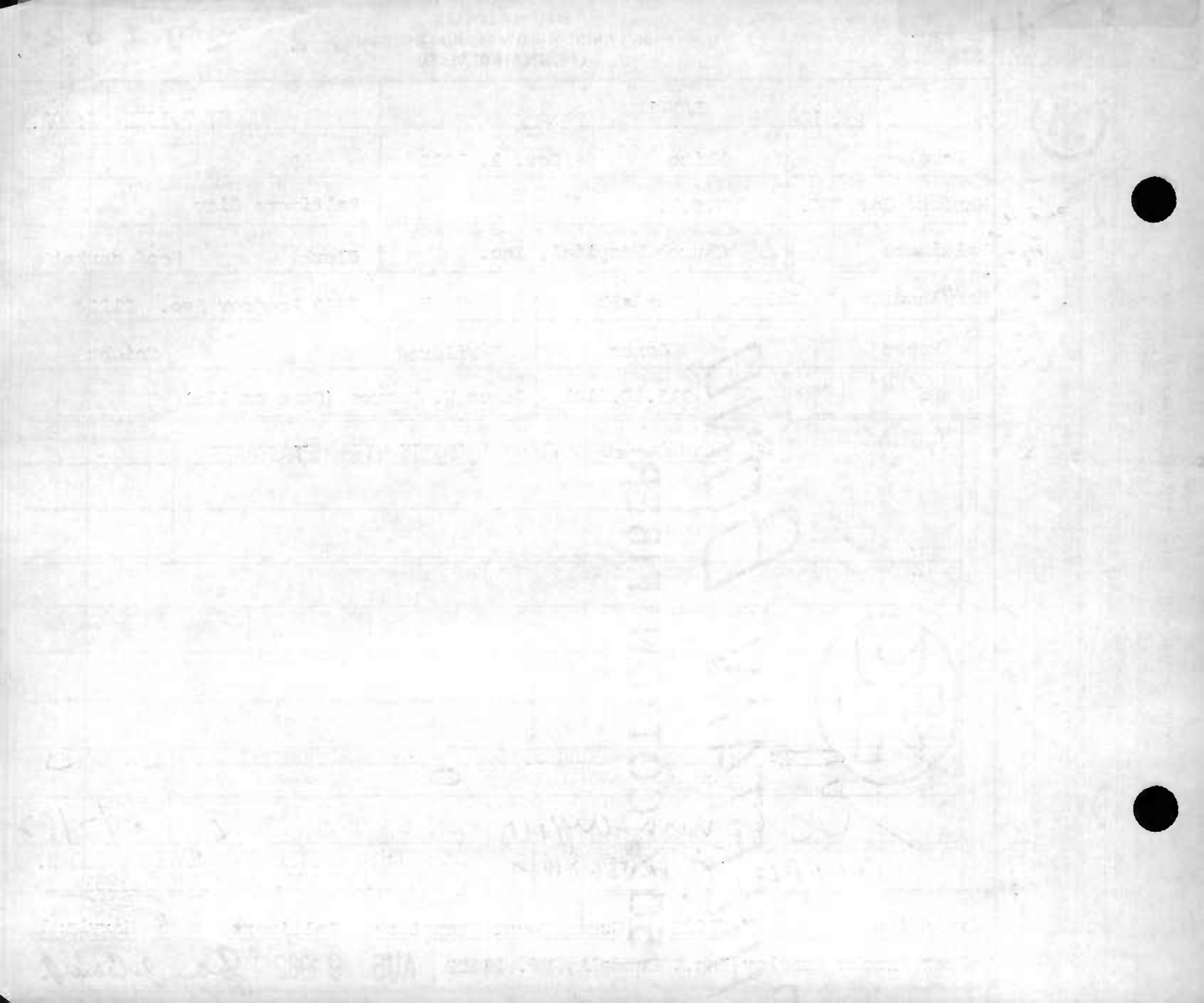


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IMPORTANT: If item 21 is marked or item 18 is marked only injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |  |  | 8 2 2 0 7 6 2 |  |
|--|--|---|--|---|--|--|--|--|--|---------------|--|
| 1 - STATE REGISTRAR  |  |   |  |   |  |  |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BERNICE LENORE PEARCE</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>AUGUST 7, 1982</b>                            |  | 2b. HOUR<br><b>6:40A.M.</b>  |  |               |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 1, 1922</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS                                     |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hanford Co., Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital, Inc.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Food Market</b>  |  |               |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  |   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Reese Jones</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mildred Knight</b>                  |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212.18.5141</b>  |  | 17. INFORMANT ADDRESS<br><b>James W. Pearce (Same as 13e)</b>   |  |  |  |  |  |               |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADVANCED CARCINOMA KIDNEY WITH METASTASES</b><br><b>1890</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |  |  |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 3</b> , 19 <b>82</b> , to <b>AUGUST 7</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>AUGUST 7</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |               |  |
| 22b. SIGNATURE <b>John J. Conner</b> DEGREE  |  |   |  |   |  | 22c. DATE SIGNED <b>8/7/82</b>   |  |  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GOPAL GURUSWAMY</b> ADDRESS <b>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231</b>  |  |   |  |   |  |  |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>8/9/1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                 |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br><b>Walter Brooks Bradley Inc., Dundalk, Md. 21222</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 9 1982</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

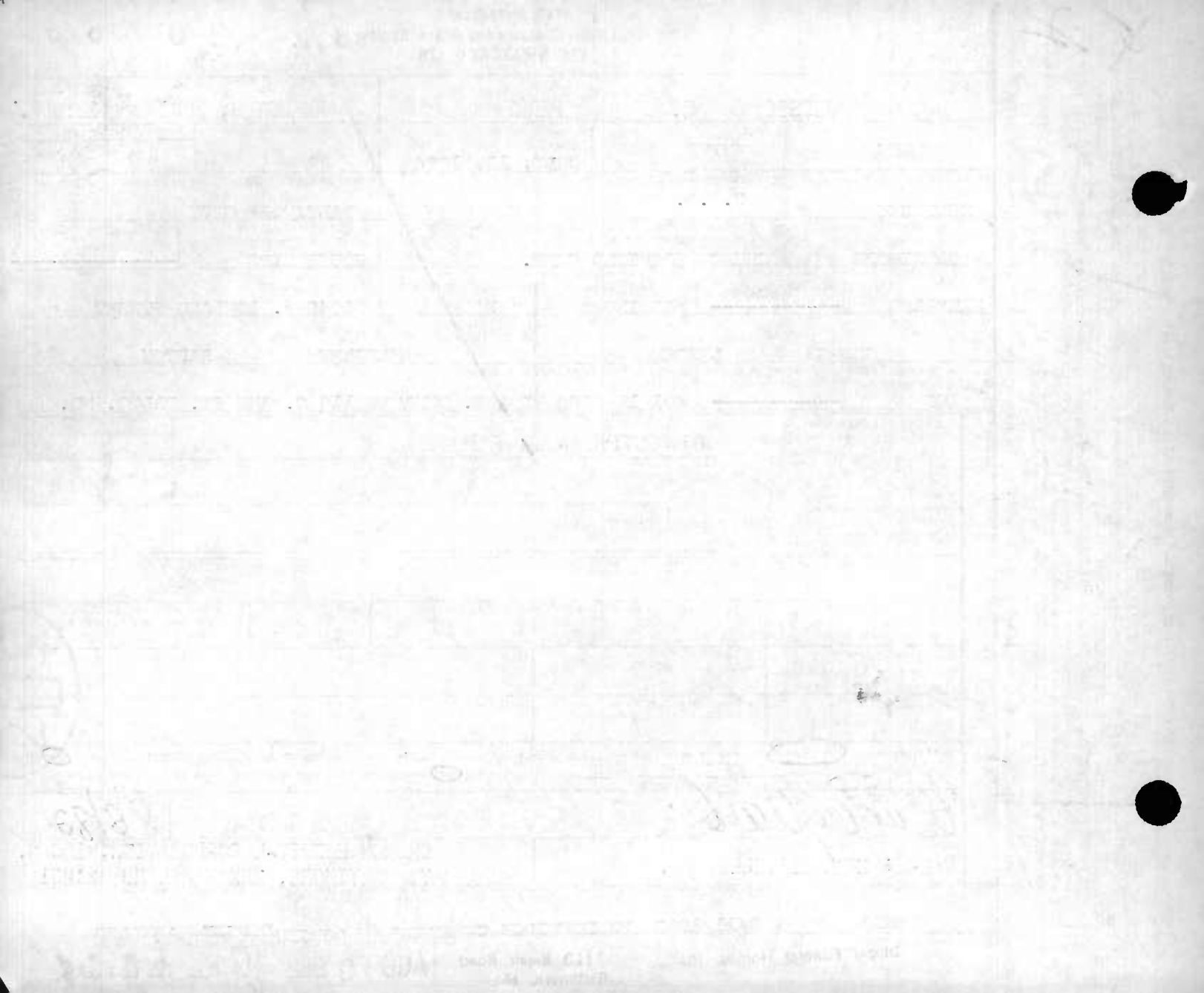
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 20 / 6 3   |  |
|---|--|---|--|--|--|
| FOR<br>1- STATE<br>REGISTRAR  |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JESSIE E. PERRY  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>AUGUST 8, 1982                          |  | 2b. HOUR<br>12:05P   |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 13, 1894   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>KENTUCKY   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL CORP. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSE WIFE |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY<br>-----   | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE LEIBEE   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARGARET BARTON               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>401 16 9968   |  | 17. INFORMANT<br>ADDRESS<br>IDA E. DUNAWAY 116 S. ANN ST. BALTO. MD.                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4280 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 8, 1982, to AUGUST 8, 1982, that (I) (we) lost the deceased alive on AUGUST 8, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                       |  |   |  |  |  |
| 22b. SIGNATURE<br>Impagliatelli   |  | DEGREE  |  | 22c. DATE SIGNED<br>8/8/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALKER IMPAGLIATELLI, MD.  |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>8/11/1982  | 23c. NAME OF CEMETERY OR CREMATORY<br>MAEDOWRIDGE CEMETERY                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>DORSEY MARYLAND  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Homes, Inc.  |  | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 10 1982   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Joan Z. Carver   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove the top papers. For safety, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trouble, please attach a separate page, signed and dated.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 6 4

REG. NO.

|  |                         |  |  |   |                            |
|--|-------------------------|--|--|---|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSHUA PERRY</b>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 24, 1982</b>          |   | 2b. HOUR<br><b>05:45AM</b> |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 16 10</b>                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71 YRS.</b>   |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |                         | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>              |                            |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                         | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |   |                            |
| 13a. STATE<br><b>Maryland</b>  |                         |  |  |   |                            |
| 13b. COUNTY<br><b>Baltimore</b>  |                         | 13c. CITY OR TOWN<br><b>Baltimore</b>                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            |
| 13e. STREET ADDRESS<br><b>706 E. Chase Street</b>  |                         |  |  |   |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joshua Perry</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Betty Anderson</b> |   |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>223-07-8911</b>                         |  | 17. INFORMANT<br>ADDRESS<br><b>Mildred Perry 1502 Arygle Avenue</b>   |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory failure</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pneumonia, empyema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>chronic obstructive pulmonary disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>2 weeks</b><br><b>4 years</b> |                         |  |  |   |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>malnutrition alcoholism renal insufficiency</b>  |                         |  |  |   |                            |
| 19a. DATE OF OPERATION<br><b>—</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>           |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                            |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                         |  |  |   |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/17</b> , 19 <b>82</b> , to <b>8/24</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                         |  |  |   |                            |
| 22b. SIGNATURE<br><b>S. E. NOLAN</b>   |                         | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>8/24/82</b>  |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. E. NOLAN</b>  |                         | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                          |  |   |                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>8/28/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Cem.</b>  |                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |                         |  |  |   |                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 26 1982</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Ganeh</b>  |                            |

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U.S. AIR FORCE

11-11-77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 6 5  
REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEON A. PERSKIE</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 21, 1982</b>                            |  | 2b. HOUR<br><b>8:40 PM</b>                               |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 10, 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3737 CLARKS LANE APT. 203 (21215)</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF-EMPLOYED</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PHOTOGRAPHER</b> |
| 13a. STATE<br><b>MARYLAND</b>  |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JACOB PERSKIE</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LENA ABRAMOWITZ</b>                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WWI</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>213-28-0125A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. LEAH PERSKIE 3737 CLARKS LANE APT. 203 21215</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>Metastatic Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Congestive Heart Failure</b>  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 17, 1982</b> , to <b>August 21, 1982</b> , that (I) (we) last saw the deceased alive on <b>August 20, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Kenneth L. Glick MD</b>   |   |   |  | 22c. DATE SIGNED<br><b>8/23/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kenneth L. Glick MD</b>  |   |   |  | 22e. ADDRESS<br><b>Sinai Hospital Hospice Program</b>                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>AUGUST 23, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HAR SINAI CEM</b>                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>OWINGS MILLS MARYLAND</b>   |   | 23e. NAME OF CEMETERY OR CREMATORY<br><b>OWINGS MILLS</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS. INC.</b>   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 24 1982</b>                                  |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canale</b>                                  |  |

MEDICAL CERTIFICATION

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LIVING GOD

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, the physician must be called within 24 hours after death. If the death occurs in a hospital, the physician must be called within 24 hours after death. If the death occurs in a nursing home, the physician must be called within 24 hours after death. If the death occurs in a prison, the physician must be called within 24 hours after death. If the death occurs in a mental hospital, the physician must be called within 24 hours after death. If the death occurs in a hospital, the physician must be called within 24 hours after death. If the death occurs in a nursing home, the physician must be called within 24 hours after death. If the death occurs in a prison, the physician must be called within 24 hours after death. If the death occurs in a mental hospital, the physician must be called within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 8 2 2 0 1 6 6 |  |
|--|--|---|--|---|--|---|--|--|--|---------------|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ralph J. Petchik</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 4, 1982</b>                                    |  | 2b. HOUR<br><b>5:22P M</b>   |  |               |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>DAY MONTH YEAR<br><b>Jan. 1, 1911</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>PA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR LAST DEGREE WORKING LIFE)<br><b>Steel Worker</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>  |  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD.</b>   |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3518 Lyndale Ave</b>   |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Carl Petchik</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Mika</b>  |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>184-10-4031</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Marian Petchik/Daughter/ 3518 Lyndale Ave.</b>   |  |   |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5672</b> IMMEDIATE CAUSE (a) <b>Septic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Retroperitoneal Abscess</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5 days</b> |  |   |  |   |  |   |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>16</b>   |  |   |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION<br><b>7/29/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Infected Left Iliac Bypass Graft</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that (this hospital) attended the deceased from <b>July 22</b> 19 <b>82</b> to <b>August 4</b> 19 <b>82</b> , that (we) last saw the deceased alive on <b>August 4</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X we) (did not) see the body after death.   |  |   |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE OF PHYSICIAN<br><b>Roy T. Snoot, M.D.</b>   |  |   |  |   |  | 22c. DATE SIGNED  |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |               |  |
| 22e. PHYSICIAN'S NAME (PRINT)<br><b>Roy T. Snoot, M.D.</b>   |  |   |  | 22f. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>Burial</b>  |  | 23b. DATE<br><b>Sat. 8/7/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                               |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>  |  |   |  |   |  | 25. DATE RECEIVED BY REGISTRAR<br><b>AUG 6 1982</b>   |  |  |  |               |  |
| 26. ADDRESS<br><b>3331 Brehms Lane, Balto. Md. 21213</b>   |  |   |  |   |  |   |  |  |  |               |  |

NOTED & OK



After 2/1/1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 977-1000.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 0 7 6 7  
REG. NO.

|   |  |   |  |  |  |   |   |  |  |
|---|--|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ambrasiejus Petravicius</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 29, 1982</b>            |  |  | 2b. HOUR<br>M   |   |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br><b>Dec. 7<sup>th</sup> 1893</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Lithuania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6111 Birchwood Ave.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Designer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Floral</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stasys Petravicius</b>  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Magdalena Unknown</b> |  |  | 13e. STREET ADDRESS<br><b>6111 Birchwood Ave.</b>                                   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-30-2417</b>                           |  | 17 INFORMANT ADDRESS<br><b>Magdalena Petravicius 6111 Birchwood Ave.</b> |   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiomyopathy acute</b><br>(c) <b>chronic obs lung disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (d) <b>Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |   |  | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>9/1/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Luis M. Zuniga, M.D.</b>  |  |   |  |  |  | 22e. ADDRESS<br><b>1101 Maiden Choice Lane Baltimore, Md.</b>                       |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Sept. 1, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 2 1982</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 6 8

REG. NO.

|  |  |   |  |   |  |   |  |  |  |                  |  |
|--|--|---|--|---|--|---|--|--|--|------------------|--|
| 1. STATE REGISTRAR   |  | 2a. DATE OF DEATH   |  | MONTH   |  | DAY   |  | YEAR   |  | 2b. HOUR         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 8  |  | 27 82 9:00A M    |  |
| JAMES  |  | JOSEPH  |  | PFARR   |  |   |  |  |  |                  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS. |  |
| MALE   |  | WHITE   |  | MONTH DAY YEAR<br>11 20 15  |  | 66 YRS.   |  | MONTHS DAYS                                  |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                  |  |
| MARYLAND   |  | U.S.A.  |  |   |  | BALTIMORE CITY  |  |  |  | MD.              |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                  |  |
| BALTIMORE  |  | VAMC LOCH RAVEN BLVD. BALTO. MD   |  | CONSTRUCTION  |  | LOCAL #16   |  |  |  |                  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |                  |  |
| MARYLAND   |  | ---   |  | BALTIMORE   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1831 FREDERICK AVENUE, 21223                 |  |                  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |  |  |                  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST   |  |   |  |   |  |  |  |                  |  |
| ANTHONY  |  | PFARR   |  | KATHERINE   |  | DOMIER  |  |  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |                  |  |
| YES  |  | WW II   |  | 218-10-9737   |  | JAMES J. PFARR, JR.   |  | 1831 FREDERICK AVENUE                        |  | 21223            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  | 19. IMMEDIATE CAUSE (a)   |  | 20. DUE TO, OR AS A CONSEQUENCE OF  |  | 21. DUE TO, OR AS A CONSEQUENCE OF                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                  |  |
| 1629   |  | Cardiopulmonary arrest  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | Presumed Lung Cancer  |  | -0-  |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |   |  |   |  |  |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  | None  |  |   |  |   |  |  |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |                  |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                  |  |
| 22a. I certify that <del>X</del> (this hospital) attended the deceased from <u>AUGUST 10</u> , 19 <u>82</u> , to <u>AUGUST 27</u> , 19 <u>82</u> , that <del>X</del> (we) last saw the deceased alive on <u>AUGUST 27</u> , 19 <u>82</u> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(I/we)</del> (did) <del>(not)</del> view the body after death. |  | 22b. SIGNATURE  |  | DEGREE  |  | 22c. DATE SIGNED  |  |  |  |                  |  |
| Robert E. Hertzig MD   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 8/27/82   |  |  |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |   |  |  |  |                  |  |
| Robert E. Hertzig MD   |  | 3900 LOCH RAVEN BLVD. BALTO. MD 21218   |  |   |  |   |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |                  |  |
| BURIAL   |  | 08-31-82  |  | BALTIMORE NATIONAL  |  | BALTIMORE CITY MARYLAND   |  |  |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | REGISTRAR'S SIGNATURE   |  |  |  |                  |  |
| HUBBARD FUNERAL HOME, INC.   |  | 4107 WILKENS AVE.   |  | 21229   |  | AUG 30 1982   |  | John J. Colburn                              |  |                  |  |

1982 BP

[illegible]

201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with this 72-hour death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 6 9  
REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Leo E Phelps   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>August 27, 1982  |  | 2b. HOUR<br>10 A M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 3, 1923                                   |  |
| 6. BIRTHPLACE<br>(COUNTRY)<br>MA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59<br>YRS MONTHS DAYS HOURS MIN.                  |  |
| 11. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>F.L. Deaton Medical Center |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                            |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12b. STATE<br>MD  |  | 12c. CITY OR TOWN<br>Annapolis  |  | 12d. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Phelps  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY Woods   |  | 12e. KIND OF BUSINESS OR INDUSTRY<br>Civil Service                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>022-14-9101   |  | 17. INFORMANT<br>ADDRESS<br>Same as #13  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>3320 IMMEDIATE CAUSE (a) PULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CEREBRAL ATROPHY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) PARKINSONISM  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br>DECLUBITI, CYSTOLITHOTOMY  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>August 19, 1982   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>BLADDER CARCINOMA   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 27, 19 82 to August 27, 19 82 that (I) (we) last saw the deceased alive on August 27, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br>Ann D. Carter   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>8/27/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANN D. CARTER  |  | 22e. ADDRESS<br>J.L. Deaton   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Aug. 31, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John M. Taylor & Sons - Annapolis, MD   |  | 23d. LOCATION<br>CITY OR TOWN<br>Annapolis  |  | 23e. STATE<br>AA MD  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>SEP 2 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>John L. Carter  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

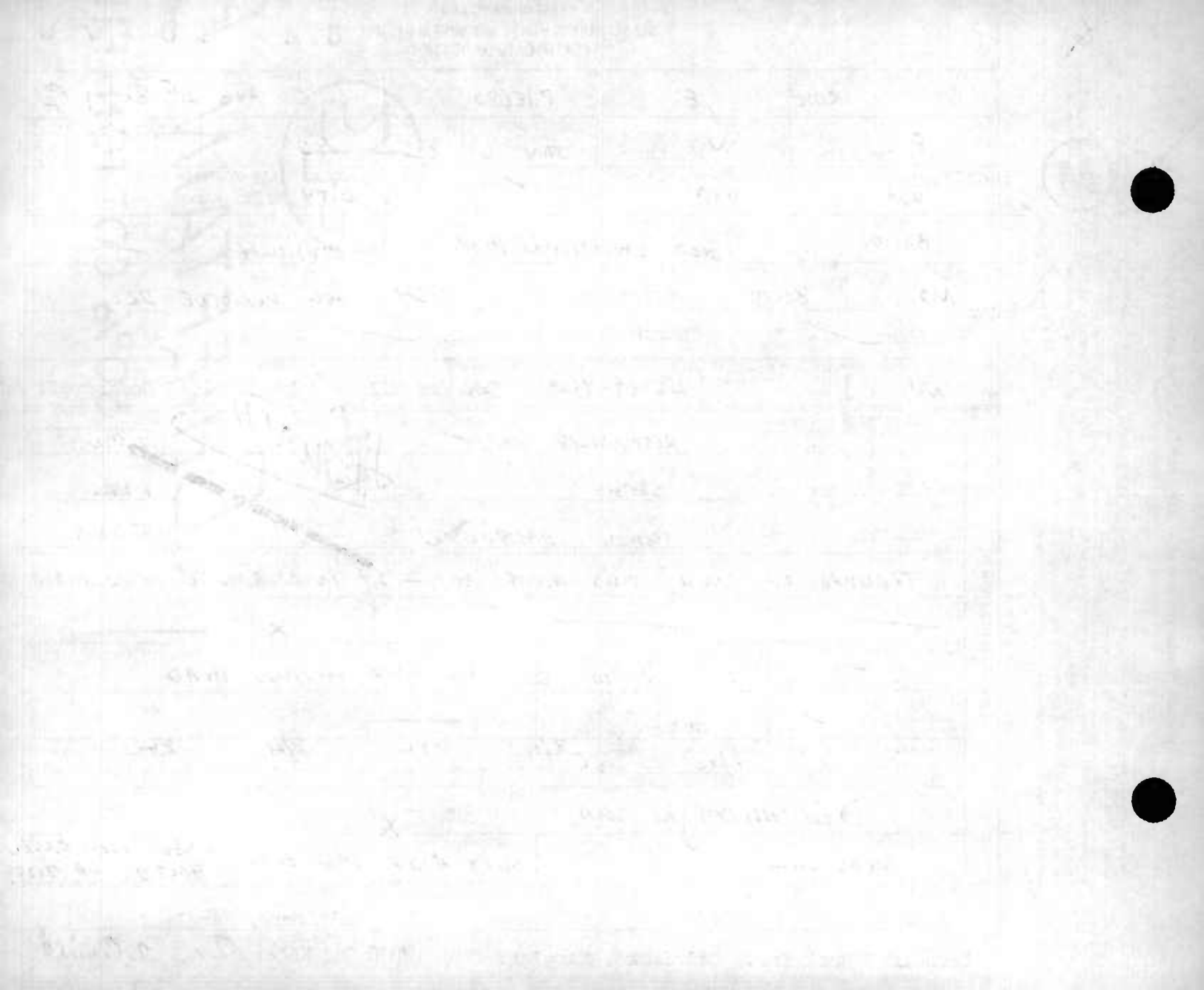
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical examiner's report must be attached to this certificate.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 0 7 7 0<br>REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RUSE E. PHELPS</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUG 21<sup>st</sup> 82</b>  |  |  |  | 2b. HOUR<br><b>1<sup>00</sup> A.M.</b>   |  |  |  |
| 3. SEX<br><b>F Female</b>  |  | 4. RACE<br><b>W White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 6 02</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 7. IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>Louisiana USA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY Baltimore</b>                        |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>   |  | 13b. CITY OR TOWN<br><b>BALTO</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>161241</b>  |  | 13e. STREET ADDRESS<br><b>1406 MERIDENE DR.</b>                                      |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anthony Charch</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Genevieve ? ?</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-9329</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mr Wilbur A Phelps 1415 Cedarcroft Rd</b>  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>5609</b><br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>BOWEL OBSTRUCTION</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 MIN.</b><br><b>1 HR.</b><br><b>5 DAYS.</b> |  |  |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>FRACTURE OF SKULL PLUS ACUTE M.I. - 2<sup>nd</sup> INTRACRANIAL HEMORRHAGE</b>  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>8/21</b>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>8/21</b>   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2 P.M. 8 10 1982</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>FELL BACK, HITTING HEAD</b>  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>HOME</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/10/1982</b> to <b>8/21/1982</b> , that (I) (we) last saw the deceased alive on <b>8/20/1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Dan McDougal M.D.</b>   |  |  |  | DEGREE<br><b>MD.</b>  |  |  |  | 22c. DATE SIGNED<br><b>8/24/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>McDOUGAL</b>   |  |  |  | 22e. ADDRESS<br><b>SUITE #137 - EAST BLDG. 5801 LOCH RAVEN BALTO. MD 21239</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/24/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 24 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>G.E. J. Conick</b>                                  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VR A 15 (4))STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 7 1

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WALTER PHILLIPS  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8-1-82  |  | 2b. HOUR P. M.<br>1:00 P.   |  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH DAY MONTH YEAR<br>MAY 2 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CITY HOSP. |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>HARD SMILING  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.   |  | 13b. COUNTY<br>BALTO.   | 13c. CITY OR TOWN<br>BALTO.  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1205 S. HIGHLAND AVE.   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>EDWARD PHILLIPS  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELIZABETH PETERS  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>212-10-2245   | 17. INFORMANT ADDRESS<br>EMMA M. PHILLIPS SAME 21224                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 MAMMARY MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 8-16-82, 19 82, to 7-29, 19 82, that (I) (we) lost saw the deceased alive on 7-29, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br>George Hebeke MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>8-2-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE HEBEKA MD   |  | 22e. ADDRESS<br>7839 WISSE AVE, Balt, MD 21222  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE)<br>BURIAL  |  | 23b. DATE<br>8-5-82   | 23c. NAME OF CEMETERY OR CREMATORY<br>OAKLAWN CEM.                       |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |
| 24. FUNERAL DIRECTOR NAME<br>HOFFMANN-SKARDA  |  | ADDRESS<br>3218 HUDSON ST.  |  | 25a. DATE REC'D-BY REGISTRAR<br>AUG-3-1982  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 7 2

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEONARD PLANTER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 30 82</b> |   |  | 2b. HOUR<br><b>8:00A</b> M  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 3 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC LOCH RAVEN BLVD. BALTO. MD</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nathan Planter</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Viola P. Planter</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br><b>219 03 6537</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Barbara Elliott 256 Robert St. Apt. D-3</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1509 IMMEDIATE CAUSE (a) **Cardiorespiratory arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **Esophageal carcinoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 12</b> , 19 <b>82</b> , to <b>August 30</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost <b>saw the deceased person August 30</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) (not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Rosemary Olivo MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>8/30/82</b>   |  | 22d. ADDRESS<br><b>3900 Loch Raven Blvd. Balto. Md. 21218</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROSEMARY OLIVO MD</b>   |  |  |  | 22f. ADDRESS   |  |  |  |

|  |  |                            |  |   |  |  |  |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                |  | 23b. DATE<br><b>9/3/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat. Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 31 1982</b>           |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8 2 2 0 7 7 3                                |
|---|--|--|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR Catherine L. Poiner  |  |  |  |   |  |   |  |  |  | REG. NO.                                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CATHERINE L. POINER</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 08 82</b>  |  | 2b. HOUR<br><b>1508</b> M  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 15 1903</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Genrl. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Factory worker</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Box Co.</b>  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Brooklyn Pk.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4406 Ritchie Hgwy. (21225)</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nathan Poiner</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Stella unknown</b>   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-03-5343</b>   |  | 17. INFORMANT ADDRESS<br><b>James M. Brower (same as 13e)</b>   |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4140 IMMEDIATE CAUSE (a) Cardiac arrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASHD.</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>16</b>  |  |  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Alex Hertzman</b>  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HERTZMAN</b>  |  |  |  | 22e. ADDRESS  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/13/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Balto., Md. 21225</b>  |  |  |  | 24b. ADDRESS<br><b>John J. Gonce F.H. 4001 Ritchie Hgwy.</b>  |  | 25a. DATE REC'D BY REGISTRAR<br><b>AUG 10 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gonce</b>   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified.

| FOR<br>1- STATE<br>REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 0 7 7 4<br>REG. NO.  |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>KATHRYN PONTIER</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-26-82</b>   |  |  |  | 2b. HOUR<br><b>2:45 A.M.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 16 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Hairdresser</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Private</b>                                  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Lutherville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2300 Dulaney Valley Rd 21093</b>                           |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexander Thomson</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary McQuire</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-32-3036</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Sr. M. Kenneth McQuire 13 S Poppleton St 21201</b>               |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>2859 IMMEDIATE CAUSE (a) cardiac arrest,</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>anemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Anemia, sinus tachycardia</b>  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>11:50 P.M. 8/25 1982 8/26 3AM 82</b>    |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/25 11:50 P.M. 1982</b> to <b>8/26 3AM 1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>8/26 1:00 AM 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>M. Amos</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>8/26/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. Amos</b>   |  |  |  | 22e. ADDRESS<br><b>321 St. Paul Place Balto, MD</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>8-28-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home 6500 York Rd 21212</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE<br><b>SEP 2 1982 John J. Conner</b>     |  |  |  |  |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 7 5

REG. NO.

|  |  |   |   |   |  |  |   |  |   |  |
|--|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Leon C. Potter</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 11 1982</b>              |   |  | 2b. HOUR<br><b>M</b>   |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 20 1916</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64 66</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>427 S. Joplin St.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Pipe Fitter</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>---</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>427 S. Joplin St.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Potter</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Unknown</b> |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>    |   | 17. INFORMANT ADDRESS<br><b>Yolanda Potter 427 S. Joplin St.</b> |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4241</b> IMMEDIATE CAUSE (a) <b>CHF and Massive aortic Regurgitation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>aortic Regurgitation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>R. Sajadi</b>   |  |   | DEGREE<br><b>M.D.</b>   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>9-11-82</b>              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAJADI</b>   |  |   | 22e. ADDRESS<br><b>CHURCH Hospital 100 N Broadway</b>                     |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Aug. 12 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Crematory</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler, Inc. 1901 Eastern Ave.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 13 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>  |   |  |   |  |

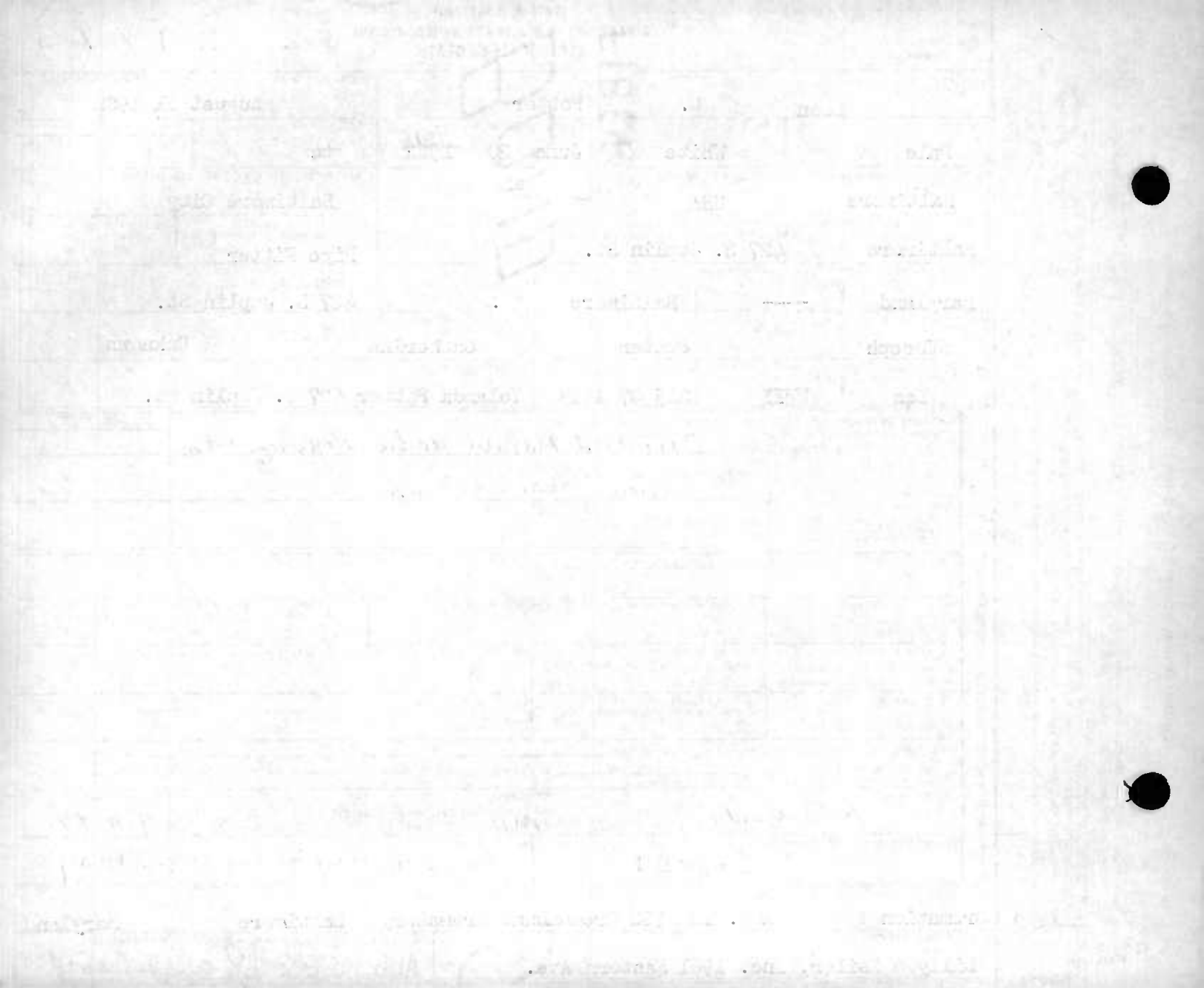
MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |  |   |   |   |
|---|---|--|---|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MARION E. Powell</b>  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-7-1982</b>                               |   | 2b HOUR<br><b>00:55 AM</b>  |
| 3 SEX<br><b>F</b>   | 4 RACE<br><b>W</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-23-1924</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                          |   |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Key Circle Hospice</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mach. Op.</b> | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Tack Co.</b>                                       |   |
| 13a STATE<br><b>Md.</b>   |   |  | 13b COUNTY<br><b>Baltimore</b>  | 13c CITY OR TOWN<br><b>Baltimore</b>  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Ipsen</b>  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia ALFORD</b>              |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b SOCIAL SECURITY NO.<br><b>212-12-7097</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>W. Michael G. Powell - 928 Garden Dr.</b>                   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>2371</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CEREBRO VASCULAR ACCIDENT.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PINEALOMA BRAIN.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Few minutes</b> |   |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |  |   |   |   |
| 19a DATE OF OPERATION<br><b>-</b>   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br><b>-</b>  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>-</b>   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>-</b> |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK<br><b>-</b>  |   | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>-</b>   |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>-</b>                              |   |
| 22a I certify that (I) (this hospital) attended the deceased from <b>8-7-82</b> 19 <b>82</b> , to <b>8-7</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8-7-82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |   |  |   |   |   |
| 22b SIGNATURE<br><b>Surjit</b>  |   |  | DEGREE<br><b>MD</b>   |   | 22c DATE SIGNED<br><b>8/9/82</b>  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SURJIT JULKA</b>   |   |  | 22e ADDRESS<br><b>107-109 E Saratoga St Baltimore</b>                               |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |   | 23b DATE<br><b>8-10-82</b>   | 23c NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE CEM.</b>                        |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Walt Hyde - 2334 E. Howard St</b>   |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>AUG 09 1982</b>                                  |   | 25b REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 when any injury, or other traumatic event, the medical examiner or coroner must be notified.

REPORT 8

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 7 7

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |  |  |
|---|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIE DEWEY POWELL</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 22 82</b> |   |  | 2b. HOUR<br><b>2:45p M</b>   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 21, 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC BALTIMORE MD 21218</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner</b>   |  |  |
|   |  |   |   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Taxi</b>                                   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Rodgers Forge</b>  |  |  |
|   |  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>117B Dumbarton Rd.</b>                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 218-22-7448</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Ann L. Botzler 239 Stanmore Rd.</b>                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>2989 IMMEDIATE CAUSE (a) Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Dementia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |   |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that <b>XX</b> (this hospital) attended the deceased from <b>AUGUST 9</b> , 19 <b>82</b> , to <b>AUGUST 22</b> , 19 <b>82</b> , that <b>XX</b> (we) last saw the deceased alive on <b>AUGUST 22</b> , 19 <b>82</b> , and that <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X we) (did) (did not)</b> view the body after death.   |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Suzanne Scattergood</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>8-22-82</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Suzanne Scattergood</b>   |  |   |   | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Aug. 25, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto. Co., Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 27 1982</b>   |  |  |  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 2 0 7 7 8   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Ann Elizabeth Prewer  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>August 25, 1982 M  |  |  |  |
| 1. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 3 1902  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Canada   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3100 St. Paul Street |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Medical Worker-Johns Hopkins   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>City   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS<br>3100 St. Paul Street   |  |  |  |
| 14. FATHER'S NAME (TYPE OR PRINT)<br>Canon George Prewer  |  |  |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)<br>Mary Vincent  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>212-30-2004   |  | 17. INFORMANT ADDRESS<br>Mary Vincent Martin, New York, New York   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4254 IMMEDIATE CAUSE (a) <u>Chronic Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 16, 1982</u> to <u>25 Aug 1982</u> , that (I) (we) last saw the deceased alive on <u>16 Aug 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did <u>not</u> view the body after death.                              |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Anderson Renick M.</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>8-26-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Anderson Renick M.   |  |  |  | 22e. ADDRESS<br>7600 Osler Drive, Towson, Maryland 21204  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>8-27-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Crematory   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 30 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>   |  |

5-10-52

TO: Mr. J. Edgar Hoover  
FROM: Mr. [illegible]  
SUBJECT: [illegible]  
RE: [illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above. One copy of the same is being furnished to the [illegible] at [illegible].

Very truly yours,  
[Signature]  
[Title]  
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (not be returned by the hospital or attending physician).

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbon paper. Again, and 7 should be detached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, we need to know the cause of the injury or event.

| 1. FOR STATE REGISTRAR   |  | Wm. E. PRICE   |  | STATE OF MARYLAND  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  | 8 2 2 0 7 7 9       |  | REG. NO.           |  |
|--|--|--|--|--|--|---|--|---------------------|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR     |  |
| William  |  | E  |  | Price  |  |   |  | 8                   |  | 20 82              |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))   |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS.   |  |
| Male   |  | White  |  | MONTH DAY YEAR   |  | 74  |  | MONTHS DAYS         |  | HOURS MIN.         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                     |  |                    |  |
| Kent Co. Md.   |  | USA  |  |  |  | Baltimore City  |  |                     |  |                    |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                     |  |                    |  |
| Baltimore  |  | Univ. Of Md. Hosp.   |  | Farmer   |  | Retired   |  |                     |  |                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                    |  |
| Md.  |  | Kent   |  | Still Pond   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  | P.O. Box            |  |                    |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                     |  |                    |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |   |  |                     |  |                    |  |
| John F. Price, Sr.   |  | Cora Dority  |  |  |  |   |  |                     |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                     |  |                    |  |
| no   |  | 213 18 5810  |  | I. Marie Price - Still Pond, Md.   |  |   |  |                     |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | Seizures   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                     |  |                    |  |
| 1541   |  |  |  |  |  |   |  |                     |  |                    |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  | (b)  |  | Rectal Carcinoma   |  |   |  |                     |  |                    |  |
|  |  | (c)  |  |  |  |   |  |                     |  |                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  | Renal Failure  |  | BOPD, Liver Metastasis   |  | ascities  |  | Sepsis              |  |                    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                |  |                     |  |                    |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  |                     |  |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |                     |  |                    |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |                     |  |                    |  |
|  |  | P.M. 19  |  |  |  |   |  |                     |  |                    |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY              |  | STATE              |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |   |  |                     |  |                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 7-27-  |  | 19 82  |  | to 8-20   |  | 19 82               |  | that (I) (we) lost |  |
| saw the deceased alive on  |  | 8-20   |  | 19 82  |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |                     |  |                    |  |
| above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |                     |  |                    |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED  |  |                     |  |                    |  |
| Lawrence S. Segman   |  |  |  |  |  | 8/20/82   |  |                     |  |                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |                     |  |                    |  |
| S/G MAN  |  | 22 S. Green St   |  | Baltimore  |  |   |  |                     |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN        |  | COUNTY STATE       |  |
| Burial   |  | 8/23/82  |  | Still Pond, Md.  |  | Cemetery  |  | Still Pond,         |  | Md.                |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                     |  |                    |  |
| J. Wallis Well   |  | AUG 25 1982  |  | John J. Conner   |  |   |  |                     |  |                    |  |
| NAME   |  | ADDRESS  |  |  |  |   |  |                     |  |                    |  |
|  |  | Chestertown, Md.   |  |  |  |   |  |                     |  |                    |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's name must be noted at the bottom of this page.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 2 0 / 8 0   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JEANETTE PRITZKER   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8/20/82   |  |  |  |
| 2. SEX<br>FEMALE  |  |  |  | 2b. HOUR<br>8:20 A.M.   |  |  |  |
| 3. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1899 3 1988  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br>83 26x YRS.   |  |
| 7a. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>North Charles General Hosp.   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| 13a. STATE<br>MD.   |  |  |  | 13b. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS<br>NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ISAAC FRIEDMAN   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>IDA ROSENTHAL   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>219-10-1030  |  | 17. INFORMANT ADDRESS<br>IRVING PRITZKER APT. 303<br>2 CANDLEMAKER CT. BALTO., MD 21208   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/22, 1982, to 8/20, 1982, that (I) (we) lost saw the deceased alive on 8/20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>A.C. Chouvalit, M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>8/20/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.C. CHOUVALIT, M.D.   |  |  |  | 22e. ADDRESS<br>N. CHARLES GEN. HOSP. -- BALTO., MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>AUG. 22, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW YOUNG MEN  |  | 23d. LOCATION CITY COUNTY STATE<br>BALTIMORE MARYLAND  |  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 24 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conish   |  |

83813-NPT-0505



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

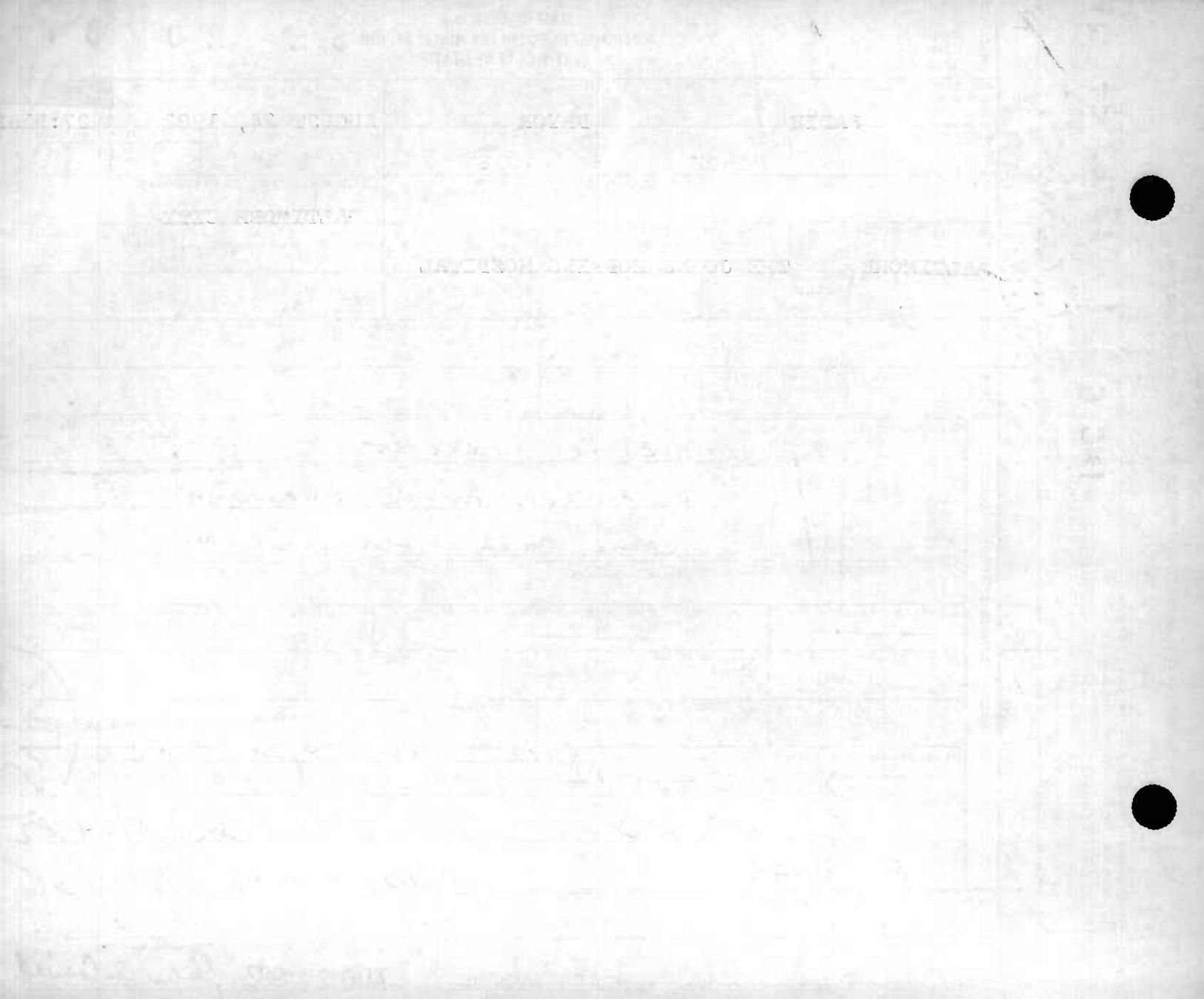
|   |  |                              |                   |  |                                  |   |  |                                   |          |                     |  |
|---|--|------------------------------|-------------------|--|----------------------------------|---|--|-----------------------------------|----------|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                               |  |                              | FIRST MIDDLE LAST |  | 2a. DATE OF DEATH MONTH DAY YEAR |   |  |                                   | 2b. HOUR |                     |  |
| SADIE   |  |                              | PRYOR             |  | AUGUST 24, 1982                  |   |  |                                   | 07:54 AM |                     |  |
| 3. SEX  |  | 4. RACE                      |                   | 5. DATE OF BIRTH   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                |          | 8. IF UNDER 24 HRS. |  |
| Female  |  | BLACK                        |                   | MONTH DAY YEAR<br>3 18 23  |                                  | 59 YRS  |  | MONTHS DAYS HOURS MIN.            |          |                     |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                          |  | 10. CITIZEN OF WHAT COUNTRY? |                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |          |                     |  |
| Maryland  |  | USA                          |                   | THE JOHNS HOPKINS HOSPITAL   |                                  | BALTIMORE CITY  |  | BALTIMORE CITY                    |          | MD.                 |  |
| 13a. STATE  |  | 13b. COUNTY                  |                   | 13c. CITY OR TOWN  |                                  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS               |          |                     |  |
| Maryland  |  |                              |                   | Baltimore  |                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 353 So. Spring Court              |          |                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                               |  |                              |                   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |                                  |   |  |                                   |          |                     |  |
|   |  |                              |                   |  |                                  |   |  |                                   |          |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  |                              |                   | 16b. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT ADDRESS   |  |                                   |          |                     |  |
| No  |  |                              |                   | 218-18-8283  |                                  | Dollie Pryor 277 So. Herring Ct.                                    |  |                                   |          |                     |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |
| IMMEDIATE CAUSE (a) CARDIAC ARREST  |  | 0  |  |
| 4413  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (b) RUPTURED AORTIC ANEURYSM  |  | 0  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c) LARGE THORACIC ABDOMINAL AN.  |  |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/22, 19 82, to 8/24, 19 82, that (I) (we) last saw the deceased alive on 8/24, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED   |  |  |  |
| E. Ruas MD   |  |   |  | 8/24/82  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |  |  |
| E. RUAS  |  | JOHNS HOPKINS HOSPITAL  |  |  |  |  |  |

|   |  |           |  |  |  |   |  |
|---|--|-----------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |
| BURIAL                                    |  | 8/29/82   |  | Md. Veteran Cem.   |  | Crownville Md.                          |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS         |  |           |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |  |   |  |
| Wm. C. March F/H 1101 E. North Avenue     |  |           |  | AUG 27 1982 John J. Carver                               |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2218010365002

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 3 SEX   |  | 4 RACE  |  |
| Robert Lee Purnell  |  | MALE  |  | Black   |  |
| 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |
| MONTH DAY YEAR<br>8 06 09   |  | 73 YRS  |  | U.S.A.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |
| BALTO Md.   |  |   |  | City MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |
| BALTO   |  | Provident   |  | R.R. Shipyard.  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STATE  |  | 13b. COUNTY   |  |
| Shipyard.   |  | Md.   |  |   |  |
| 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |
| BALTO   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1716 N. Smallwood St.   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |
| FIRST MIDDLE LAST<br>UNK.   |  | FIRST MIDDLE LAST<br>Betty Decker   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS  |  |
| NO  |  | 218-01-7365   |  | Ruby Purnell 1716 N. Smallwood.   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY   |  |   |  |   |  |
| IMMEDIATE CAUSE (a) Bronchogenic Cancer of  |  |   |  |   |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |
| (b) Lung - Pneumonia.   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |
| (c)   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
|   |  | P.M. 19   |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-13-82 to 8-14-82 that (I) (we) lost the deceased alive on 8-14-82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE  |  | 22c. DATE SIGNED  |  |
| H. Devadoss   |  | M.D.  |  | 8/14/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |
| H. Devadoss   |  | Provident Hospital  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (IF BY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 8-19-82   |  | King Mem Pk.  |  |
| 23d. LOCATION   |  | 23e. NAME OF CEMETERY OR CREMATORY  |  | 23f. LOCATION   |  |
| CITY OR TOWN COUNTY STATE   |  |   |  | CITY OR TOWN COUNTY STATE   |  |
| Baltimore Md.   |  |   |  | Baltimore Md.   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| NAME ADDRESS<br>JAS. A. MORTON & SONS 1701 LAURENS  |  | AUG 18 1982   |  | John J. Smith   |  |

1914-1915

24th of May 1915  
Dear Sir,  
I have the pleasure to acknowledge the receipt of your letter of the 18th inst. in relation to the above matter.  
I am sorry to hear that you are unable to attend the meeting on the 26th inst. but I am sure that your absence will not be felt.  
I am, Sir, very respectfully,  
Yours faithfully,  
J. H. [Name]

Enclosed for you are the following documents:  
1. A copy of the report of the Committee on the subject of the proposed new building.  
2. A copy of the report of the Committee on the subject of the proposed new building.  
3. A copy of the report of the Committee on the subject of the proposed new building.  
4. A copy of the report of the Committee on the subject of the proposed new building.

I am, Sir, very respectfully,  
Yours faithfully,  
J. H. [Name]

Very truly yours,  
J. H. [Name]

2

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 8 3

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br><b>EVELYN D. QUEEN</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 16 82</b>  |  | 2b. HOUR<br><b>6:18 P</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 11 1930</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV. MD HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES T JONES</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA M WEST</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  |
| 16a. SOCIAL SECURITY NO.<br><b>214-26-3207</b>   |  | 17. INFORMANT ADDRESS<br><b>Alnet T Queen 1617 Frederick</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY Arrest</b><br>5720<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MASSIVE HEPATIC NECROSIS</b><br>18 DAYS<br>(c) <b>CAVERNOUS HEPATIC Hemangioma</b><br>YEARS |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>Acute Renal Failure</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>7-1-1982</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>HEPATIC Abscesses</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL ROSSINI, JR MD</b>   |  |   |  | 22c. ADDRESS<br><b>22 S. GREEN ST Balto, MD.</b>  |  | 22d. DATE SIGNED<br><b>8/16/82</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8-21-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 18 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be signed by the medical examiner.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <u>Leroy</u>   |  |  | FIRST MIDDLE LAST <u>Queen</u>  |  |  | 2a DATE OF DEATH MONTH DAY YEAR <u>8/7/82</u>   |  |  | 2b HOUR <u>11:45 AM</u>   |  |  |
| 3 SEX <u>male</u>   |  |  | 4 RACE <u>Black</u>   |  |  | 5 DATE OF BIRTH MONTH DAY YEAR <u>1 1 19</u>  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS. MONTHS DAYS HOURS MIN.                        |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>mo</u>  |  |  | 7b CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> MD.   |  |  |
| 10 CITY OR TOWN OF DEATH <u>Baltimore</u>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Provident Hosp.</u>                       |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a STATE <u>mg</u>   |  |  | 13b COUNTY  |  |  | 13c CITY OR TOWN <u>Baltimore</u>   |  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <u>Edward Queen</u>  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Jennie Nicholson</u>   |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>  |  |  | 16b SOCIAL SECURITY NO. <u>215-18-7192</u>  |  |  |
| 17 INFORMANT ADDRESS <u>215-18-7192 Florence Wiggins 720 N. Denise</u>  |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 5609 |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemorrhagic Shock</u>   |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute GI bleeding</u>                                 |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Intestinal obstruction</u>   |  |  | 19a DATE OF OPERATION <u>7/23/82</u>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intestinal obstruction</u>  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M.   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)              |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>8/7/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  | 22b. SIGNATURE <u>Ted Lemke</u> DEGREE <u>MD</u>  |  |  | 22c. DATE SIGNED <u>8/7/82</u>  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ted Lemke</u>  |  |  | 22e. ADDRESS <u>Provident Hospital</u>  |  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  |  | 23b. DATE <u>8/12/82</u>  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Co. md</u>  |  |  | 24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H</u> ADDRESS <u>1101 E. North</u>  |  |  | 25a. DATE REC'D. BY REGISTRAR <u>AUG 11 1982</u>  |  |  |
| 25b. REGISTRAR'S SIGNATURE <u>John J. Coniff</u>  |  |  |   |  |  |   |  |  |   |  |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed immediately after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Page 1 of 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be called on duty.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8 2 2 0 7 8 5  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Jeston J. Quinby</b>  |  |   |  | August 10, 1982 M   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>January 6, 1924</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>58</b>  |  |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>704 Edmondson Avenue</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Jewelry Appraiser</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jeston J. Quinby</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Agnes Taylor</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-16-5166</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mary Quinby Same as # 13</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF LUNG WITH</b><br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CNS METASTASES</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a _____  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 11</b> 19 <b>82</b> to <b>AUGUST 10</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>MARCH 31</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If less) I am not sure the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Diana Griffiths</b>   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Diana Griffiths</b>  |  | 22e. ADDRESS<br><b>St. Agnes Hospital, Baltimore, Md.</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/13/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Dorsey Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Witzke P.A.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 12 1982</b>   |  |   |  |
| 1630 Edmondson Avenue, Catonsville, Md. 21228  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20786

1- FOR  
STATE  
REGISTRAR

|   |  |              |  |   |  |   |  |   |   |  |  |
|---|--|--------------|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Marie Rachuba  |  |              | 20. DATE KNOWN OF DEATH<br>ESTIMATED<br>8 1 1982<br>MONTH DAY YEAR   |   |  | 21. HOUR<br>M   |  |   |   |  |  |
| 3. SEX<br>F   |  | 4. RACE<br>W |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 6 16 65 |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>65 YRS.   |  | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. |   |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |              | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |  | 10. MARRIED<br>WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore City   |  |              | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>641 S. Montford Avenue |   |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TAVERN OWNER  |  |   | 15. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>130. STATE<br>Md.   |  |              | 131. COUNTY<br>Baltimore   |   |  | 132. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |   | 133. STREET ADDRESS<br>641 S. Montford Ave.   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Rostkowski   |  |              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances WOZNIAK   |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |   | 17. SOCIAL SECURITY NO.   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. |  |              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  | 19. DATE OF OPERATION   |  |   | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |
| 21. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |              | 22. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  | 23. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   | 24. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 25. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |              | 26. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   |  | 27. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   | 28. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |
| 29. ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.  |  |              | 30. TITLE (SPECIFY)<br>M.D. Assistant  |   |  | 31. MEDICAL EXAMINER  |  |   | 32. DATE SIGNED<br>8/2/82   |  |  |
| 33. EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |              | 34. ADDRESS<br>111 Penn St. Balto., MD.  |   |  | 35. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Entombment   |  |   | 36. 23b. DATE<br>8-5-82   |  |  |
| 37. 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Rosary   |  |              | 38. 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore CA MD.   |   |  | 39. 24. FUNERAL DIRECTOR<br>NAME<br>R.H. Kaczorowski  |  |   | 40. ADDRESS<br>2525 Fleet St  |  |  |
| 41. 25. DATE REC'D. BY REGISTRAR<br>AUG - 4 1982  |  |              | 42. 25. REGISTRAR'S SIGNATURE<br>James J. Nathan   |   |  | 43. 26. DATE REC'D. BY REGISTRAR<br>AUG - 4 1982  |  |   | 44. 26. REGISTRAR'S SIGNATURE<br>James J. Nathan  |  |  |

DATA

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SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 8 2 2 0 7 8 7                                       |  |  |  |
|--|--|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>LEO   |  | MIDDLE<br>E.  |  | LAST<br>RAGAS  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 30 82  |  |   |  | 2b. HOUR<br>7:20 P <sub>M</sub>              |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 27 35   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>47 YRS.   |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                      |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.  |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1602 Olive Street |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Driver   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Trucking       |  |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>1602 Olive St.  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>135-22-2094  |  | 17. INFORMANT<br>Evelyn Priller   |  |  |  | ADDRESS<br>312 Julius Lane<br>Pasadena, Md.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>1541<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Metastatic carcinoma retron</u><br>(c) <u>Chronic respiratory insufficiency</u> |  |  |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><u>Liver metastatic disease</u>  |  |  |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>8/15/82  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Small bowel obstruction  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Santiago Zamudio</u>  |  | DEGREE<br>MD   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED                                    |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SANTIAO ZAMUDIO   |  | 22e. ADDRESS<br>3001 S Hanover St. Balto. MD 21230   |  |   |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  | 23b. DATE<br>8/30/82   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  |  |  | ADDRESS<br>Balto., Md.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u> |  |  |  |



*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the middle section of the page.]*

*[Faint, mostly illegible handwritten text at the bottom of the page, possibly a signature or date.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | 8 2 2 0 7 8 8<br>REG. NO.                                  |  |               |  |
|---|--|---|--|--|--|--|--|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOHN LEO RANKIN</b> |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>AUGUST 12, 1982</b> |  | 2b. HOUR<br>M |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 11, 1903</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>79</b>  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                                |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                   |  |  |  |  |  |               |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2218 Cloville Ave.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inspector</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City Sanitation</b>   |  |  |  |               |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET ADDRESS<br><b>3822 Bank St.</b>  |  |  |  |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Hugh F. Rankin</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Frances Gadden</b>          |  |  |  |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |  | 17 INFORMANT<br><b>Mary E. Rankin</b>  |  | ADDRESS<br><b>2218 Cloville Ave. 21214</b>   |  |  |  |  |  |               |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1579</b> IMMEDIATE CAUSE (a) <b>metastatic adenocarcinoma -</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>probably pancreatic origin</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |  |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/14</b> 19 <b>82</b> , to <b>8/12</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/1</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |  |  |  |  |               |  |
| 22b. SIGNATURE<br><b>Davis Hahn</b>   |  |   |  | DEGREE<br><b>MD</b>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/13/82</b>                         |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Davis Hahn, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>5601 Loch Raven Blvd. Balto., Md.</b>   |  |  |  |  |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Aug. 16, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanilaus</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                              |  |  |  |  |  |               |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>   |  |   |  | ADDRESS<br><b>6500 York Rd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR IN REGISTRAR'S SIGNATURE<br><b>AUG 19 1982</b> <b>John J. Conish</b> |  |  |  |  |  |               |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |                                   | 8 2 2 0 7 8 9   |  |
|--|--|--|--|--|--|---|--|--|-----------------------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |  |  |   |  |  |                                   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |  |  | 2a. DATE OF DEATH   |  |  |                                   | 2b. HOUR  |  |
| Nathaniel Ransom   |  |  |  |  |  | 8 25 82   |  |  |                                   | M   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |                                   | 7b. IF UNDER 24 HRS.  |  |
| Male   |  | Black  |  | 1 1 33   |  | 49 YRS  |  | MONTHS DAYS  |                                   | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |                                   |   |  |
| S. Carolina  |  | USA  |  |  |  | Baltimore City MD.  |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| Baltimore  |  | 2323 Callo Avenue  |  |  |  |   |  |  |                                   |   |  |
| 13a. STATE   |  |  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |                                   | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |  |  |  |  |   |  | Baltimore  |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |                                   |   |  |
| Willie Ransom  |  |  |  |  |  | Gracie Beard  |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |                                   |   |  |
| No   |  |  |  |  |  | 251-50-0879   |  | Idella Rankin 25 s. monastery Ave.                             |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| IMMEDIATE CAUSE (a) 1509 Cardiac arrest  |  |  |  |  |  |   |  |  |                                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of the  |  |  |  |  |  |   |  |  |                                   | 1 year  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) esophagus and profuse sinus   |  |  |  |  |  |   |  |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a   |  |  |  |  |  |   |  |  |                                   |   |  |
| Status post resection for cancer of the left lung  |  |  |  |  |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |   |  |
| 9/9  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | 21d. INJURY OCCURRED  |  |  |                                   |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  | P.M. 19  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |                                   |   |  |
| 21f. LOCATION  |  | STREET   |  | CITY OR TOWN   |  | COUNTY  |  | STATE  |                                   |   |  |
| 21g. WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | AT WORK  |  |  |  |   |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 82, to 8/24 19 82, that (I) (we) last saw the deceased alive on 8/24 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |                                   |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |                                   |   |  |
| Charles A. H. Stein  |  |  |  |  |  | 8/25/82   |  |  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |  |                                   |   |  |
| Charles A. H. Stein  |  | Johns Hopkins  |  |  |  |   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. STATE   |                                   |   |  |
| BURIAL   |  | 8/29/82  |  | Eastview Mem Pk.   |  | Baltimore   |  | Md.  |                                   |   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                                   |   |  |
| Wm. C. March F/H 1101 E. North avenue  |  | AUG 27 1982  |  |  |  | John J. Conish  |  |  |                                   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 122 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |   |  |
|---|--|---|--|---|--|--|--|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO: 82 20790   |  |   |  |  |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR  |   |  |
| FIRST MIDDLE LAST<br>Helen Claudia Ravitz   |  |   |  |   | MONTH DAY YEAR<br>08/29/82   |  |  | 11 <sup>01</sup> A.M.                               |   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | 7. IF UNDER 1 YEAR                                  |   |  |
| Female  |  | White   |  | MONTH DAY YEAR<br>Sept. 15 1917   |  | 64 YRS   |  | IF UNDER 24 HRS.                                    |   |  |
| 7a. BIRTHPLACE<br>COUNTRY   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |   |   |  |
| Md.   |  | U.S.A.  |  |   |  | Baltimore City MD.   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                   |   |  |
| Baltimore   |  | Baltimore City Hospital   |  |   |  | Floorlady  |  | Lever Bros.   |   |  |
| 13a. STATE  |  |   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?  |  |
| Md.   |  |   |  |   |  |  | Baltimore  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  |   |   |  |
| Joseph Zuchowski  |  |   |  |   | Frances Kaminski   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS                                    |   |   |  |
| no  |  |   |  |   | 216-12-5650  |  | Robt. Tenaglia (son) 1909 Maryland Ave.                  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>4310</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Hemorrhage</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |   |  |  |  |   |   |  |
| MEDICAL CERTIFICATION   |  |   |  |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |   |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |   |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>8/25</u> , 19 <u>82</u> , to <u>8/29</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>8/29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.  |  |   |  |   |  |  |  |   |   |  |
| 22b. SIGNATURE<br><u>Gordon Raphael</u>   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><u>8/29/82</u>                  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Gordon Raphael</u>  |  |   |  |   | 22e. ADDRESS<br><u>Baltimore City Hospital</u>   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE          |   |  |
| Burial  |  |   | 9/1/82   |   | Sacred Heart of Jesus  |  |  | Balto. Md.  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Schmunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>AUG 31 1982</u>              |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carver</u> |   |  |



1948





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 should be filled in.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |  | 8-2 20791  |   |
|---|---|---|--|--|---|
| 1. FOR<br>STATE<br>REGISTRAR  |   |   |  | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anníe M. REA</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>8-18-82</b>                                      |  | 2b. HOUR <b>1:10 PM</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 10, 1895</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L Deaton Med C 611 S. Charles St</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Governess</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Franklin Jones</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Judith Whelan</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212 24 9295</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Melvin Hardiman, Same</b>                           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100 Cardíopulmonary arrest</b><br>IMMEDIATE CAUSE (a) <b>3/P MI</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>PCVA</b>  |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7/30 P.M. 19 82</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/17 19 82</b> to <b>8/18 19 82</b> , that (I) (we) last saw the deceased alive on <b>8/17 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                             |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Brian Dapern MD</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>8/18/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Brian Dapern MD</b>   |   | 22e. ADDRESS<br><b>Deaton Med C 611 S. Charles St Balt, MD</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>8/21/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Gate</b>                               |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crozet, Virginia</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>AUG 19 1982</b>   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |   | 24b. ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>   |  | 25. REGISTRAR'S SIGNATURE<br><b>John J. Gahring</b>                                  |   |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  | REG. NO.   |  |                     |  |
|---|--|--|--|---|--|---|--|--|--|--|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY E. MIDDLE REASIN LAST  |  |  |  |   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>August 18 1982 |  | 2b. HOUR<br>2:56 AM |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 26, 1920   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 7b. IF UNDER 24 HRS.<br>HOURS MIN.                 |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |  |  |                     |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2720 Matthews Street  |  |  |  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Vernon Clark Funk   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anne Parks   |  |   |  |  |  |  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 24 8596   |  | 17. INFORMANT<br>George A. Reasin   |  |   |  | ADDRESS<br>Same  |  |  |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>1552<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CANCER OF THE LIVER</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 MINUTES |  |  |  |   |  |   |  |  |  |  |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |  |  |   |  |   |  |  |  |  |  |                     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |  |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |                     |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>AUG 5</u> 19 <u>82</u> , to <u>AUG 18</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>AUG 18</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |                     |  |
| 22b. SIGNATURE<br><u>Michael Shear MD</u>   |  |  |  | DEGREE<br>MD  |  |   |  | 22c. DATE SIGNED<br>8/18/82  |  |  |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL L SHEAR  |  |  |  | 22e. ADDRESS<br>2720 MATHEWS STREET   |  |   |  |  |  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>8/21/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Co., MD                                   |  |  |  |  |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 19 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>  |  |  |  |                     |  |

400 York Road, New York, N.Y. 10011  
Henry W. Jackson & Sons Co.  
212 Madison Avenue, New York, N.Y. 10017

Wm. A. Jackson & Sons Co.  
212 Madison Avenue, New York, N.Y. 10017

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Wm. A. Jackson & Sons Co.  
212 Madison Avenue, New York, N.Y. 10017

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |   |   |                                    |  |  |  |   | REG. NO. 20793                                   |  |
|---|--|----------------------|---|---|------------------------------------|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES ALLEN REAVES</b>   |  |                      |   |   |                                    | 2a. DATE KNOWN OF DEATH <b>8-7-82</b>  |  | 2b. HOUR <b>6:31A</b>  |   |  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Black</b> |   | 5. DATE OF BIRTH <b>11 17 25</b>                            |                                    | 6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.   |  | 7c. DATE PRONOUNCED DEAD <b>8-7-82</b>   |   | 7d. HOUR <b>6:31A</b>                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>   |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Baltimore City</b> |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2406 Monticello Road</b> |   |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                |  |
| 13a. STATE <b>MD</b>  |  |                      | 13b. COUNTY   |   | 13c. CITY OR TOWN <b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 13e. STREET ADDRESS <b>2406 Monticello Rd.</b>                    |  |  |
| 14. FATHER'S NAME <b>Thomas Reaves</b>  |  |                      |   |   |                                    | 15. MOTHER'S MAIDEN NAME <b>Musettie Hardy</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      |   | 16b. SOCIAL SECURITY NO. <b>246-20-1435</b>                 |                                    | 17. INFORMANT ADDRESS <b>Catherine Reaves 2406 Monticello Rd</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                      |   |   |                                    |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |   |   |                                    |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                    |  |  | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |   |   |                                    |  |  |  |   |  |  |
| ACTUAL SIGNATURE <b>Margaret A. Koroll</b>  |  |                      |   | TITLE (SPECIFY) <b>M.D. Assistant</b>                       |                                    |  |  | DATE SIGNED <b>8-10-82</b>   |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margaret A. Koroll, M.D.</b>   |  |                      |   | ADDRESS <b>111 Penn Street</b>                              |                                    |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      |   | 23b. DATE <b>8/12/82</b>                                    |                                    | 23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville MD</b>                    |   |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>   |  |                      |   |   |                                    | ADDRESS <b>11041 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1982</b>                                 |   | 25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b> |  |

RECEIVED



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 9 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES A REDDICKS</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 3 82</b> |  |  | 2b HOUR<br><b>9 28 AM</b>  |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 10 22</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b>              |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a STATE<br><b>Maryland</b>   |  | 13b COUNTY  |  | 13c CITY OR TOWN<br><b>Baltimore</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>3631 Park Heights Avenue</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles H Reddicks</b>   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith Coles</b>   |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b SOCIAL SECURITY NO.<br><b>215-14-4043</b>   |  | 17 INFORMANT ADDRESS<br><b>Alonzo Charles Reddicks 3631 Pk Heig</b>  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____ |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I (this hospital) attended the deceased from <b>7/31</b> 19 <b>82</b> to <b>8/3</b> 19 <b>82</b> , that (I (we) last saw the deceased alive on <b>8/3</b> 19 <b>82</b> , and that in (my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.       |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Isaiah Dimery</b>   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>8-3-82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ISAIAH Dimery</b>  |  |   |  | 22e. ADDRESS<br><b>2600 Liberty Hts</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8/9/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat. Cem</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                             |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm.C. March F/H 1101 E. North Ave.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 06 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | 8 2 2 0 7 9 5                                  |           |   |                       |
|--|--|---|--|---|--|---|--|---|--|--|-----------|---|-----------------------|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |   |  |   |  |  |           |   |                       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Pearl  |  | MIDDLE<br>M.  |  | LAST<br>Reddish   |  | 2a. DATE OF DEATH   |  | MONTH<br>8                                     | DAY<br>25 | YEAR<br>82                                      | 2b. HOUR<br>1:20 P.M. |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH  |  | MONTH<br>4  |  | DAY<br>8  |  | YEAR<br>92                                     |           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS       |                       |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>M.D.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City  |  |   |  |  |           |   |                       |
| 10. CITY OR TOWN OF DEATH<br>Balto   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Caton Manor NC |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Housewife |           |   |                       |
| 13a. STATE<br>M.D.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3330 WILKENS AVE   |  |  |           |   |                       |
| 14. FATHER'S NAME<br>FIRST<br>John   |  | MIDDLE<br>rmi   |  | LAST<br>Elliott   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Lida   |  | MIDDLE<br>---   |  | LAST<br>Elliott                                |           |   |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>213-48-6474   |  | 17. INFORMANT<br>Norman W Reddish   |  | ADDRESS<br>806 White Ave  |  | Baltimore MD.   |  |  |           |   |                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) Atherosclerotic cardiovascular disease.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c)                            |  |   |  |   |  |   |  |   |  |  |           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Organ Brain Syst; Decubitus ulcers hips  |  |   |  |   |  |   |  |   |  |  |           |   |                       |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |           |   |                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |           |   |                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |           |   |                       |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-29-19-74 to 8-25-19-82, that (I) (we) lost<br>saw the deceased alive on 8-14-19-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |           |   |                       |
| 22b. SIGNATURE<br>Darshan M. S. Saluja   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  |   |  | 22c. DATE SIGNED                               |           |   |                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DARSHAN M. S. SALUJA MD   |  | 22e. ADDRESS<br>1600 MT Royal Ave, Balto 21217  |  |   |  |   |  |   |  |  |           |   |                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>8/28/1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, A.A. Co., Md.                          |  |   |  |  |           |   |                       |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home   |  | ADDRESS<br>Balto., Md., 21225<br>237 E. Patapsco Ave.,  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 30 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver  |  |   |  |  |           |   |                       |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 0 7 9 6<br>REG. NO.  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>John A. Reed   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>August 8, 1982   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 14 26  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MD  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Reed   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Olivia   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>216-20-5294  |  | 17. INFORMANT ADDRESS<br>Sarah K. Gee 5009 Norwood Avenue   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden death - ? myocardial infarction or CVA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Hypertensive C. disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>13 yrs</u> |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>4100</u>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/29/84</u> to <u>8/7/84</u> that (I) (we) last saw the deceased alive on <u>8/7/84</u> and that in (my) (our) opinion death occurred on the date and hour on <u>8/8/84</u> from the cause stated above, (I) (we) (and) (did not) view the body after death.   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>X <u>Elija Saunders</u>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>8/9/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elija Saunders, M. D.   |  | 22e. ADDRESS<br>2 Hamill Rd. Ste 320 Balto., Md. #10  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>8/13/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>AUG 10 1982  |  |  |  |
| 25. REGISTRAR'S SIGNATURE<br>John J. Conner  |  |   |  |  |  |  |  |



Handwritten text, possibly a signature or date, appearing upside down.

Handwritten text, possibly a signature or name, appearing upside down.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 9 7

REG. NO.

|   |  |  |  |
|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bartlett</b> <small>MIDDLE</small> <b>C. Regan Sr.</b>   |  | 2a. DATE OF DEATH <b>8-9-82</b> <small>DAY</small> <b>9</b> <small>YEAR</small> <b>1982</b> <small>2b. HOUR</small> <b>1:20 AM</b>   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>cauc</b>  |  |
| 5. DATE OF BIRTH <b>1/18/12</b> <small>MONTH</small> <b>1</b> <small>DAY</small> <b>18</b> <small>YEAR</small> <b>12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>70 years</b> <small>IF UNDER 1 YEAR</small> <b>MONTHS</b> <b>0</b> <small>IF UNDER 24 HRS</small> <b>DAYS</b> <b>0</b> <b>HOURS</b> <b>0</b> <b>MIN.</b> <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> <small>MD.</small>  |  |
| 10. CITY OR TOWN OF DEATH <b>CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>  |  |
| 12a. USUAL OCCUPATION <b>Cable Splicer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD.</b>   |  | 13b. COUNTY <b>Balto. City</b>   |  |
| 14. FATHER'S NAME <b>William</b> <small>MIDDLE</small> <b>J.</b> <small>LAST</small> <b>Regan</b>   |  | 15. MOTHER'S MAIDEN NAME <b>Catherine</b> <small>MIDDLE</small> <b>Rain</b> <small>LAST</small>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OF UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>212-03-6941</b>  |  |
| 17. INFORMANT (wife) <b>Marie A. Regan</b>  |  | ADDRESS <b>701 N. Luzerne Ave. 21205</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. <b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest / Hypotension</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Probable sepsis, Adenocarcinoma of cecum, Pulmonary Embolism, CHF.</b>  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY <b>19</b> <small>HOUR A.M.</small> <small>MONTH</small> <small>DAY</small> <small>YEAR</small>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21e. LOCATION <b>201 University Parkway</b> <small>CITY OR TOWN</small> <b>Baltimore</b> <small>COUNTY</small> <b>Md.</b> <small>STATE</small>  |  | 21f. LOCATION <b>Baltimore</b> <small>CITY OR TOWN</small> <b>Md.</b> <small>COUNTY</small> <b>Md.</b> <small>STATE</small>  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 30</b> , 19 <b>82</b> , to <b>August 9</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>August 9</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>0</b> (we) <b>did</b> (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE <b>Wendy Kloesz</b> <small>DEGREE</small> <b>MD</b>  |  | 22c. DATE SIGNED <b>8/9/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wendy Kloesz</b>   |  | 22e. ADDRESS <b>201 University Parkway</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>   |  | 23b. DATE <b>8/12/82</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Cemetery</b>  |  | 23d. LOCATION <b>Baltimore</b> <small>CITY OR TOWN</small> <b>Md.</b> <small>COUNTY</small> <b>Md.</b> <small>STATE</small>  |  |
| 24. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc.</b>   |  | 25. RECEIVED BY <b>John J. Lohmeyer</b>  |  |
| 3331 Brehms Lane Balto, Md. 21213   |  | AUG 10 1982  |  |

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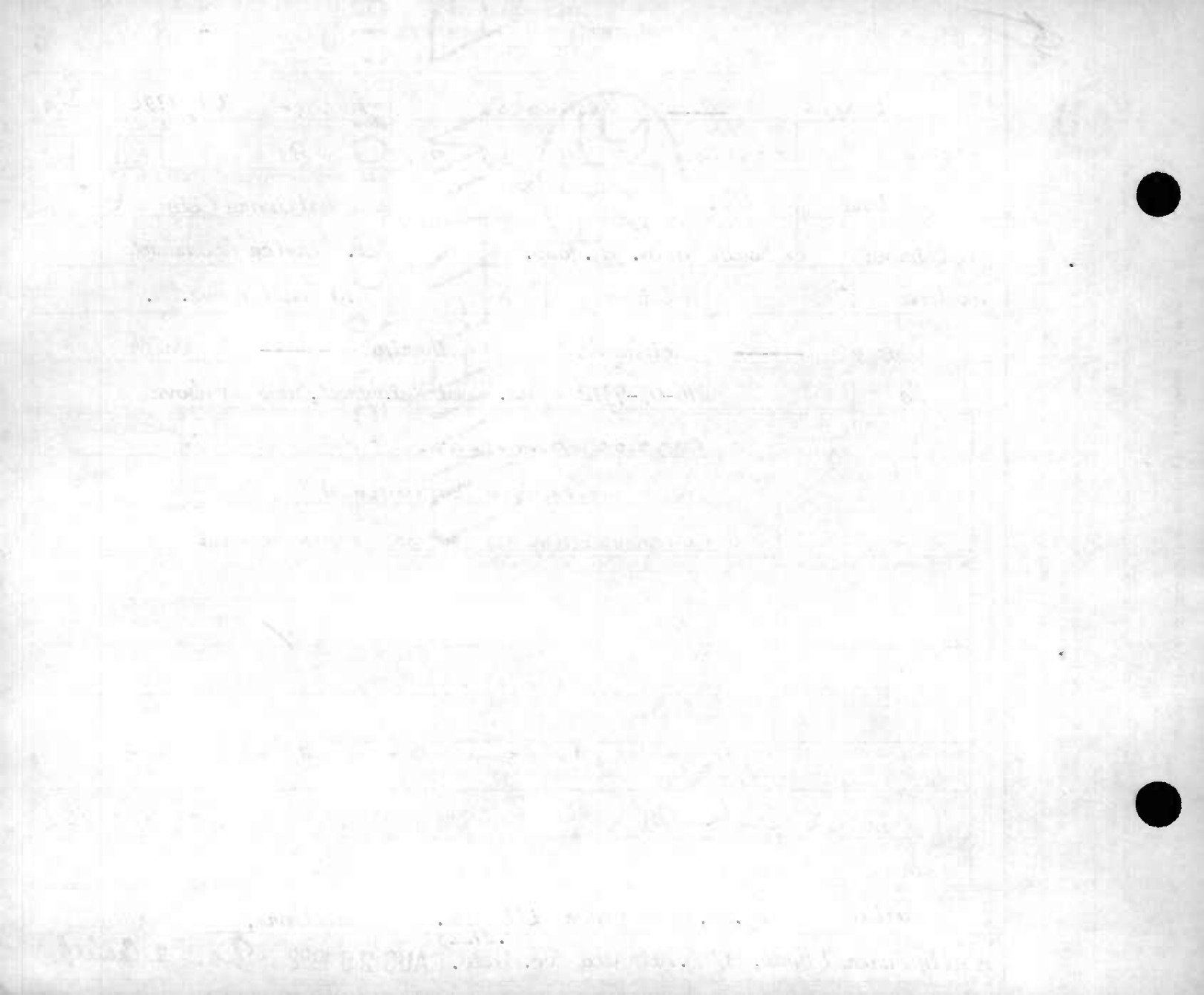


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached by use of the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

| STATE OF MARYLAND   |  |   |   |   |  |  |                     |   |  |
|---|--|---|---|---|--|--|---------------------|---|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   |   |  |  |                     |   |  |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |                     |   |  |
| REG. NO. 82 20798   |  |   |   |   |  |  |                     |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Louis ----- Reinhardt  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>August 21, 1982 |   |  |  | 2b. HOUR<br>1:30 AM |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 30 1900  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS  |                     | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |                     |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balto. Gen. Hosp. |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Service Attendant  |                     | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                     | 13e. STREET ADDRESS<br>410 Pontiac Ave. Bk.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George ----- Reinhardt   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Katherine ----- Adolph  |  |  |                     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>216-07-9312   |   | 17. INFORMANT ADDRESS<br>Mrs. Naomi Reinhardt, Same as above  |  |  |                     |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEVERE NEUROLOGIC DYSFUNCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CEREBROVASCULAR ACCIDENT OR TUMOR NECROSIS</u> |  |   |   |   |  |  |                     |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |  |                     |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |                     |   |  |
| 21d. INJURY OCCURRED<br>IMAGE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                     |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/14, 1982, to 8/21, 1982 that (I) (we) last saw the deceased alive on 8/21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |   |   |  |  |                     |   |  |
| 22b. SIGNATURE<br>James T. Heisler M.D.   |  |   |   | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                     | 22c. DATE SIGNED<br>8/21/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James T. Heisler   |  |   |   | 22e. ADDRESS<br>3001 S. Hanover St  |  |  |                     |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Aug. 24, 1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cent.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |                     |   |  |
| 24. FUNERAL DIRECTOR<br>McCutty Funeral Home, 237 E. Patapsco Ave. Balto.   |  |   |   | DATE REC'D. BY REGISTRAR<br>AUG 25 1982   |  | REGISTRAR'S SIGNATURE<br>John J. Conish  |                     |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 7 9 9

REG. NO.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Baby Samuel M. Restivo Jr.</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Aug. 1, 1982</i>                                      |   | 2b. HOUR<br>M   |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Dec. 8, 1980</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>1 8</i>         | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1401 Marshall St. Balto. Md.</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>None</i>                 | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><i>Maryland</i>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>1401 Marshall St. Balto. Md.</i>                |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Samuel M. Restivo, Sr.</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Deborah Wheat</i>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>None</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>Deborah Wheat, Same as above</i>           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Airway Obstruction</i><br>5198<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Neurological Defects</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>inability to swallow</i>                 |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ( )  |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |
| 22b. SIGNATURE<br><i>Samuel R Williams, MD</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SAMUEL R Williams</i>   |  | 22e. ADDRESS<br><i>5411 Old Frederick Rd Suite 12</i>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   | 23b. DATE<br><i>Aug. 4, 1982</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Cross Cemetery</i>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i>   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>McGully Funeral Home, 130 E. Font Ave. Balto. Md.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>AUG 06 1982</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Lohr</i>                         |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

| 1 - STATE REGISTRAR  |         | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                   | REG. NO. 872 20800  |          |
|--|---------|--|-------------------|---|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  | 2a. DATE OF DEATH |   | 2b. HOUR |
| FIRST  | MIDDLE  | LAST   | MONTH             | DAY   | YEAR     |
| OTIS E. REW  |         |  | 8/28/82           |   | 3:18 PM  |
| 1. SEX   | 4. RACE | 5. DATE OF BIRTH   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)   |          |
| Female   | White   | MONTH DAY YEAR<br>Oct. 25, 1899  |                   | 82 YRS.   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |          |
| W. Virginia  |         | USA  |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |          |
| BALTIMORE  |         | UNION MEMORIAL HOSPITAL  |                   | Homemaker   |          |
| 13a. STATE   |         | 13b. COUNTY  |                   | 13c. CITY OR TOWN   |          |
| Maryland   |         |  |                   | Baltimore   |          |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |                   | 13d. INSIDE CITY LIMITS?  |          |
| FIRST MIDDLE LAST<br>Henry Rushbrooke  |         | FIRST MIDDLE LAST<br>Annie Katherine Chambers  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |                   | 17. INFORMANT ADDRESS   |          |
| No   |         | 215 58 3927  |                   | Mrs. Gordon Harden, Owings Mills, MD  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 VENTRIC TACHICARDIA (refractory)<br>DUE TO, OR AS A CONSEQUENCE OF (b) probable MI<br>DUE TO, OR AS A CONSEQUENCE OF (c) probable CVA<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |  |                   |   |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |         |  |                   |   |          |
| probable CVA   |         |  |                   |   |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   | 20a. AUTOPSY?   |          |
|  |         |  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |          |
| 22a. I certify that (this hospital) attended the deceased from August 17, 1982, to 8/28, 1982, that (we) last saw the deceased alive on 8/28/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (did) (did not) view the body after death.            |         |  |                   |   |          |
| 22b. SIGNATURE<br>Sylvia Riggo Jagoda  |         | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                   | 22c. DATE SIGNED<br>8/28/82   |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         | 22e. ADDRESS   |                   |   |          |
| Sylvia Riggo Jagoda  |         | UNION MEMORIAL HOSPITAL  |                   |   |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY  |          |
| Burial   |         | 8/30/82  |                   | Moreland Memorial   |          |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |         | 23e. DATE REC'D. BY REGISTRAR  |                   |   |          |
| Balto. County, MD  |         | AUG 30 1982  |                   |   |          |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212   |         | 25b. REGISTRAR'S SIGNATURE<br>John J. Canfield   |                   |   |          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | 8 2 2 0 8 0 1<br>REG. NO.  |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALFRED Woodrow REYNOLD</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8-10-8 10 82</b>                  |   |  | 2b. HOUR<br><b>9:52 AM</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 21, 1929</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.               |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                       |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Washington</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS   |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George H. Reynolds</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ethel Lenora Abbott</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Shirla Parks, 842S. Potomac St., Hagerstown, Md.</b>  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>5070 IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <b>Probable Pulmonary embolism</b><br>(c) <b>Aspiration Pneumonia</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| MEDICAL CERTIFICATION   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 10   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)                         |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-4-82</b> to <b>8-10-82</b> that (I) (we) last saw the deceased alive on <b>8-10-82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Sher A Hashmi</b>  |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><b>8-10-1982</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sher A Hashmi</b>   |  |   |  | 22e. ADDRESS<br><b>2600 Liberty Hgts. Ave</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>  |  |   |  | 23b. DATE<br><b>Aug. 13, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Locust Grove Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Boonsboro Wash., Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRY PARTIAL REGISTRAR'S SIGNATURE<br><b>AUG 15 1982</b> <i>John J. Cornish</i> |  |   |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 20802

1- FOR  
STATE  
REGISTRAR

|   |         |  |  |   |  |   |  |                                      |  |   |  |
|---|---------|--|--|---|--|---|--|--------------------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |  |  | 2a. DATE KNOWN<br>OF DEATH  |  |   |  | 2b. HOUR                             |  |   |  |
| James D. Richards   |         |  |  | 8 16 1982   |  |   |  | a. m.                                |  |   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE<br>PRONOUNCED<br>DEAD       |  | 2d. HOUR  |  |
| Male  | Black   | 2 24 32  | 50   |   |  |   |  | 8 16 1982                            |  | 9:45 a. m.                                      |  |
| 9. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                      |  |   |  |
| Maryland  |         | USA  |  |   |  | Baltimore City, MD.   |  |                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |   |  |
| Baltimore   |         | 440 Pitman Place   |  |   |  |   |  |                                      |  |   |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                  |  |   |  |
| Maryland  |         |  |  | Baltimore   |  |   |  | 440 Pitman Place                     |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |                                      |  |   |  |
| William Richards  |         |  |  | Mary Williams   |  |   |  |                                      |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |   |  |                                      |  |   |  |
| No  |         | N/A  |  | Geraldine Carter 1326 E. Coldspring   |  |   |  |                                      |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Obstructive Pulmonary Disease</u><br><u>4960</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____  |         |  |  |   |  |   |  |                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |   |  |   |  |                                      |  |   |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |                                      |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                                      |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                      |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> 1, Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |                                      |  |   |  |
| ACTUAL<br>SIGNATURE   |         | TITLE (SPECIFY)<br>Assistant   |  |   |  | DATE<br>SIGNED  |  |                                      |  | 8-16-82   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         | Margarita A. Korell, M.D.  |  |   |  | ADDRESS   |  |                                      |  | 111 Penn Street                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |                                      |  |   |  |
| BURIAL  |         | 8/21/82  |  | Arbutus Cem   |  | Arbutus, Md.  |  |                                      |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |         |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                      |  |   |  |
| Wm. C March F/H 1101 E. North Avenue  |         |  |  | AUG 18 1982   |  | John J. Conner  |  |                                      |  |   |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of **BARBARA G. RICHARDSON** be certified by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 0 3

REG. NO.

|   |   |  |  |  |   |
|---|---|--|--|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Barbara G Richardson</b>  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>08/01/82</b>  |  | 2b HOUR<br><b>1:44P</b>   |
| 3 SEX<br><b>F</b>   | 4 RACE<br><b>W</b>                        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2/8/41</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>41</b> YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>V.A.</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |   |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John Hopkins Hospital</b>                  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HSWE</b>       | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><b>MD. BALTO ESSEX</b>  |   |  | 13b INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13c STREET ADDRESS<br><b>1627 RIVERWOOD RD</b>                                       |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>KYLE BLEVENS</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FAYE MOOR</b>  |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |   | 16b SOCIAL SECURITY NO.<br><b>217-32-1389</b>  | 17. INFORMANT<br>ADDRESS<br><b>W. THURMAN RICHARDSON ABOVE</b>                                 |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>2875</b> IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Gastrointestinal bleeding</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Thrombocytopenia</b>  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>9 minutes</b><br><b>1 month</b><br><b>1 month</b>                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Hemorrhagic pancreatitis, renal failure, myocardial infarction</b>   |   |  |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 2</b> , 19 <b>82</b> , to <b>Aug 1</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1:44pm Aug 1/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |  |  |  |   |
| 22b. SIGNATURE<br><b>M. Sunday</b>  |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>8/1/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. SUNDAY</b>   |   | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>8/4/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BEL AIR</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BEL AIR MD.</b>  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>   |   |  | ADDRESS<br><b>300 MACE</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG - 4 1982</b>  |
|   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Baltimore Health Department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 2 0 8 0 4<br>REG. NO.  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>William George Ricker  |  |  |  | August 25, 1982  |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Nov. 24, 1908  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Pimlico Manor Nurs. Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Builder   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employed   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>A.A.  |  | 13c. CITY OR TOWN<br>Arnold  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>George Ricker  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Snowden  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  |
| 16b. SOCIAL SECURITY NO<br>N/A   |  | 17 INFORMANT (Nephew)<br>Mr. Charles William Ricker (Apt. 204)   |  | ADDRESS 7983 Nolpark Ct. 21061   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic colon carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>rectal abscess, abdominal ulcer, peptic ulcer disease, COPD, angina</u>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> 19 <u>82</u> , to <u>8/25</u> 19 <u>82</u> , that (I) (we) lost saw the deceased after an above (I) (we) (did/did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>G. Cutler M.D.</u>   |  |  |  | DEGREE   |  | 22c. DATE SIGNED <u>8/25/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NAOMI P. CUTLER</u>   |  |  |  | 22e. ADDRESS <u>North Charles General Hospital</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>28 Aug. 82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, MD.  |  |
| 24 FUNERAL DIRECTOR'S NAME<br><u>Dean P. Charlton</u>  |  | ADDRESS<br>Glen Burnie MD.   |  | 25. DATE RECEIVED BY REGISTRAR<br>AUG 26 1982  |  |  |  |
| SINGLETON FUNERAL HOME   |  |  |  | REGISTRAR'S SIGNATURE <u>John J. Lawler</u>  |  |  |  |

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RIDEWELL, MILDRED

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

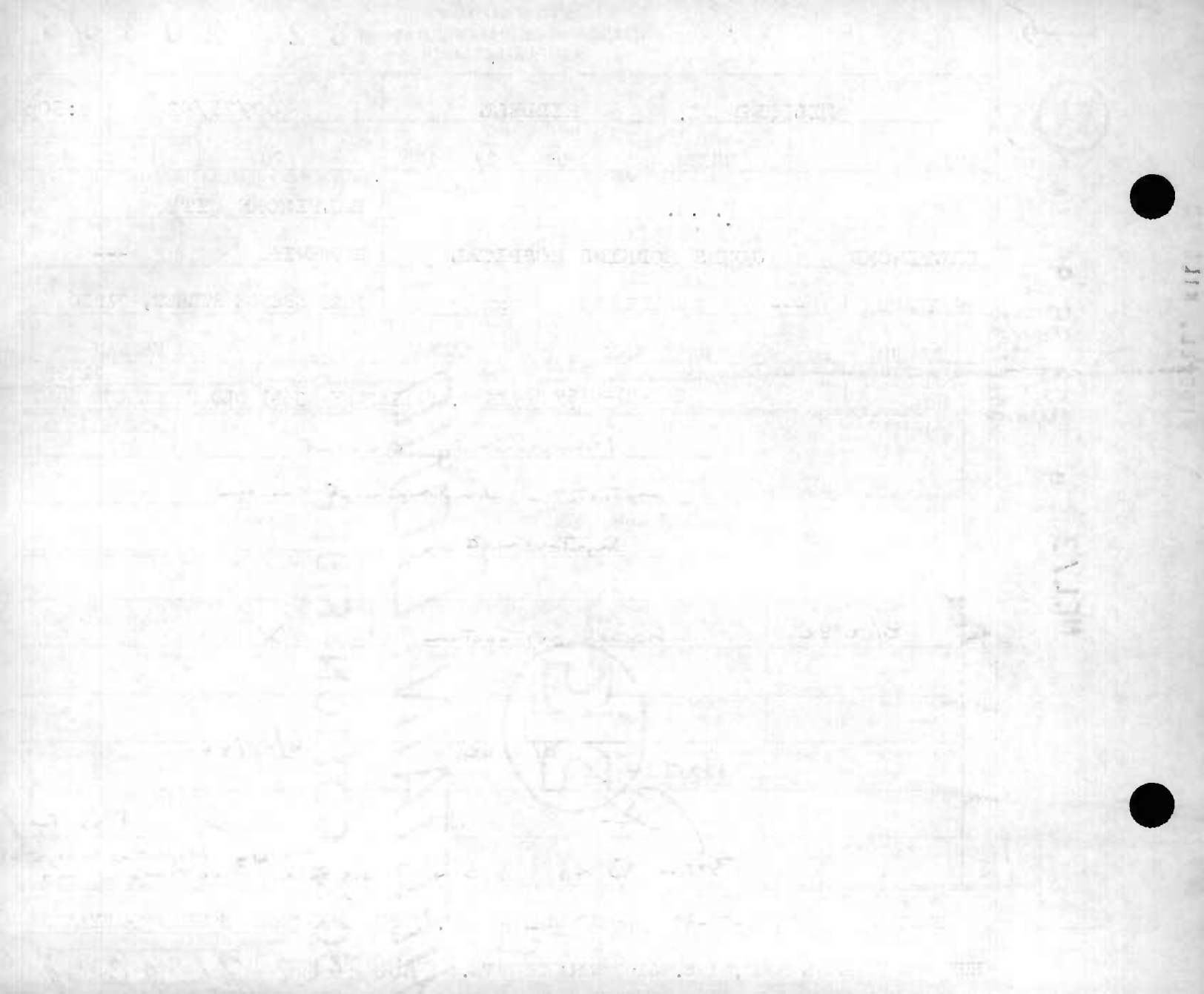
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Thereafter, the funeral director should remove carbon copies, remove the certificate from the file, and forward it to the State Department of Health and Mental Hygiene prior to burial or cremation. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

DHHM - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 2 0 8 0 5  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MILDRED I. RIDDELL</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>08/25/82</b>   |  |  |  | 2b. HOUR<br><b>6:50p</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>08 27 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>70</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>  |  | IF UNDER 74 HRS. HOURS MIN.<br><b>0 0</b>    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                            |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1820 SPENCE STREET, 21230</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>EDWARD SALISBURY</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LAURA KERNAN</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-0169</b>  |  | 17. INFORMANT ADDRESS<br><b>OLIN E. SALISBURY 3437 OLD FREDERICK ROAD 21229</b>   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br><b>1590</b><br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic endometrial cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>8/12/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>bowel obstruction</b>  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/10/82</b> , 19 <b>82</b> , to <b>8/25/82</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/25/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |   |  | DEGREE<br><b>[Signature]</b>  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/25/82</b>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Brian S. [Signature]</b>   |  |   |  | 22e. ADDRESS<br><b>600 N Broadway Baltimore MD</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>08-28-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PARK</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b>                   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>21229</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 2 2 0 8 0 6  |  |   |  |                                   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|---|--|-----------------------------------|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |   |  |  |  |  |  |   |  |                                   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><b>STANLEY</b>  |  | MIDDLE  |  | LAST<br><b>RIDLEY</b>   |  | 2a. DATE OF DEATH  |  | MONTH<br><b>8</b>  |  | DAY<br><b>25</b>  |  | YEAR<br><b>82</b>                 |  | 2b. HOUR<br><b>4:30</b> M.                     |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH  |  | MONTH<br><b>2</b>   |  | DAY<br><b>12</b>   |  | YEAR<br><b>14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |  |  |  |  |  |   |  |                                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>301 S. ANNOVER STREET, BALTIMORE</b> |  |   |  |   |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MD-21230</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>303 SEAGULL AVE BALTIMORE MD-2125</b>  |  |  |  |   |  |                                   |  |  |  |  |  |
| 14. FATHER'S NAME  |  | FIRST<br><b>Louise</b>   |  | MIDDLE  |  | LAST<br><b>Ridley</b>   |  | 15. MOTHER'S MAIDEN NAME   |  | FIRST<br><b>Belle</b>  |  | MIDDLE<br><b>Ridley</b>   |  | LAST                              |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br><b>NORA HILL, 303 SEAGULL AVE BALTIMORE MD-21235</b>   |  |   |  |  |  |  |  |   |  |                                   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>40 min.</b> |  |  |  |   |  |   |  |  |  |  |  |   |  |                                   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |  |  |   |  |                                   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |                                   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR<br>P.M.<br><b>8 25 1982</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>patient coughed and then arrested.</b>                                 |  |   |  |  |  |  |  |   |  |                                   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>S.B.G. Hospital</b>   |  | 21f. LOCATION<br>CITY OR TOWN<br>STREET<br><b>301, SOUTH. Baltimore Ave</b><br>COUNTY<br><b>MD-21230</b><br>STATE   |  |   |  |  |  |  |  |   |  |                                   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/13</b> 19 <b>82</b> , to <b>8/25</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/24</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |   |  |                                   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Vidya Munda</b>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>8/25/82</b>  |  |   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |                                   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VIDYA MUNDRA</b>   |  | 22e. ADDRESS<br><b>301 S. ANNOVER STREET BALTIMORE MD 21230.</b>   |  |   |  |   |  |  |  |  |  |   |  |                                   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/30/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cook Cem.</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br><b>Emporia Virginia.</b>   |  |  |  |   |  |                                   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. A. Rice</b>   |  | FSPA<br><b>1300</b>  |  | ADDRESS<br><b>Eutaw Pl.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1982</b>   |  |  |  |   |  |                                   |  | REGISTRAR'S SIGNATURE<br><b>John J. Connel</b> |  |  |  |

2025 COC 157

Handwritten notes and tables, mostly illegible due to extreme fading. Some visible fragments include:

Top section: *Handwritten text, possibly a title or header.*

Table 1 (approximate structure):

| Column 1 | Column 2 | Column 3 | Column 4 |
|----------|----------|----------|----------|
| ...      | ...      | ...      | ...      |
| ...      | ...      | ...      | ...      |
| ...      | ...      | ...      | ...      |

Table 2 (approximate structure):

| Column 1 | Column 2 | Column 3 | Column 4 |
|----------|----------|----------|----------|
| ...      | ...      | ...      | ...      |
| ...      | ...      | ...      | ...      |
| ...      | ...      | ...      | ...      |

Bottom section: *Handwritten text, possibly a conclusion or summary.*

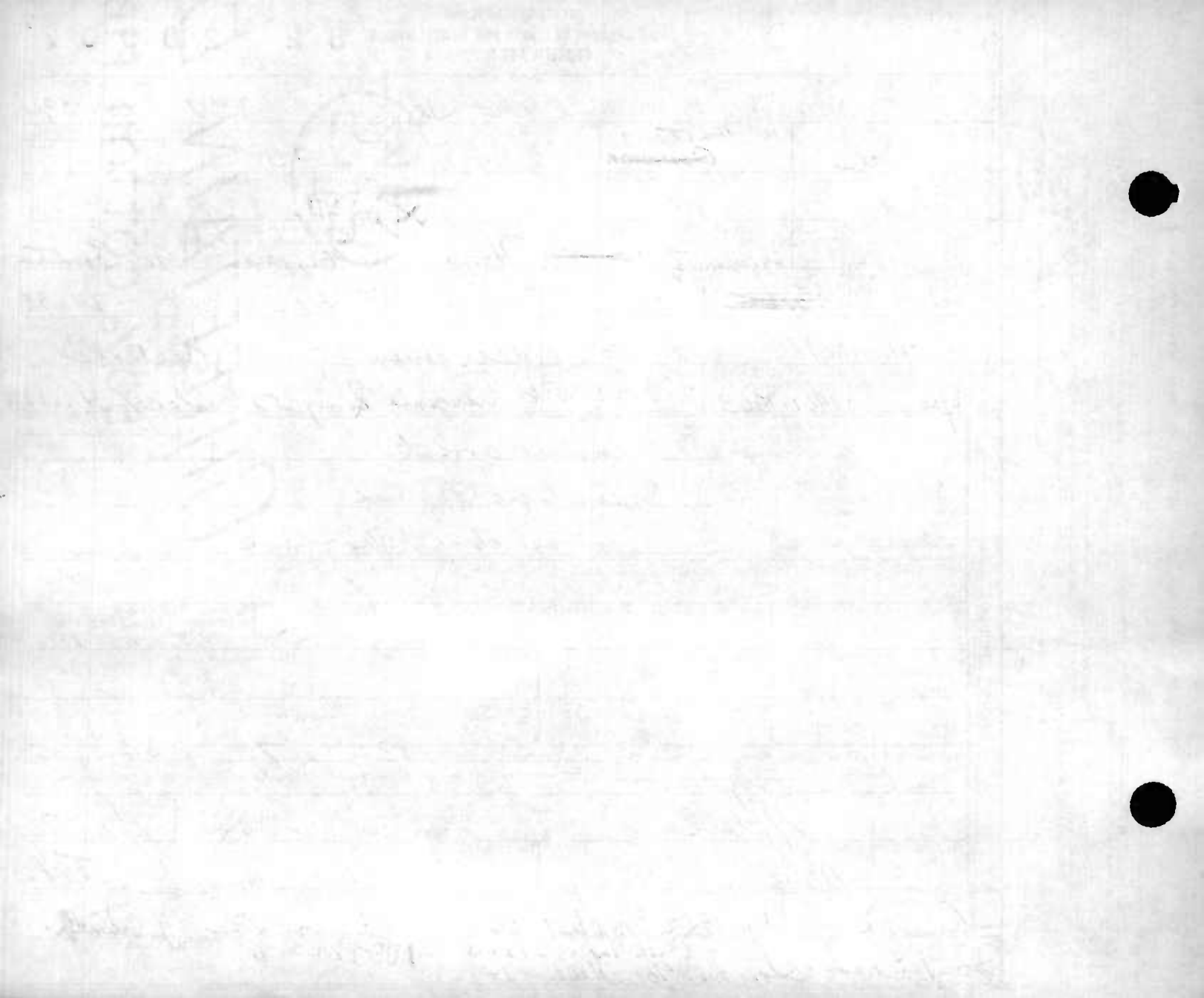
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 0 7

REG. NO.

|   |  |   |  |   |  |  |  |  |  |   |  |   |  |                              |  |                                       |  |
|---|--|---|--|---|--|--|--|--|--|---|--|---|--|------------------------------|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH  |  | MONTH   |  | DAY   |  | YEAR                         |  | 2b. HOUR                              |  |
| Michael   |  |   |  |   |  | RING JR.   |  | 8  |  | 7   |  | 8   |  | 2                            |  | 11:30 PM                              |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR   |  | 8. IF UNDER 24 HRS  |  | 9. MONTHS   |  | 10. DAYS                     |  | 11. HOURS                             |  |
| Male  |  | White   |  | 12 19 41  |  | 40 YRS   |  |  |  |   |  |   |  |                              |  |                                       |  |
| 12. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 13. CITIZEN OF WHAT COUNTRY?  |  | 14. MARRIED <input type="checkbox"/> NEVER <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 15. BALTIMORE CITY OR COUNTY OF DEATH  |  | 16. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)      |  | 17. KIND OF BUSINESS OR INDUSTRY  |  | 18. BALTO CITY  |  | 19. MD.                      |  |                                       |  |
| Ind.  |  | USA   |  |   |  | BALTO CITY   |  | Shenan   |  | Air Condition   |  |   |  |                              |  |                                       |  |
| 20. CITY OR TOWN OF DEATH   |  | 21. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 22. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 23. STATE  |  | 24. COUNTY   |  | 25. CITY OR TOWN  |  | 26. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 27. STREET ADDRESS           |  | 28. 622 Scott - 21230                 |  |
| BALTO   |  | Thurman   |  | Hosp  |  | MD   |  |  |  | BALTO   |  |   |  |                              |  |                                       |  |
| 29. FATHER'S NAME   |  | 30. MOTHER'S MAIDEN NAME  |  | 31. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)   |  | 32. SOCIAL SECURITY NO.  |  | 33. INFORMATION  |  | 34. ADDRESS   |  | 35. 1961-1963   |  | 36. 217 38 5636              |  | 37. Virginia Ring 522 Scott St. 21230 |  |
| Michael   |  | Thurman   |  | Yes   |  | 1961-1963  |  | 217 38 5636  |  | Virginia Ring 522 Scott St. 21230                                       |  |   |  |                              |  |                                       |  |
| 38. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |  | 39. IMMEDIATE CAUSE (a)   |  | 40. DUE TO, OR AS A CONSEQUENCE OF  |  | 41. (b)  |  | 42. DUE TO, OR AS A CONSEQUENCE OF                                   |  | 43. (c)   |  | 44. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  | 45. 4310                     |  | 46. cardiac arrest                    |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  | neurologic demise  |  |  |  | intracerebral hemorrhage  |  |   |  |                              |  |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                      |  | 47. DATE OF OPERATION   |  | 48. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 49. AUTOPSY?   |  | 50. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?        |  | 51. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 52. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 53. 8/7/82                   |  | 54. 8/7/82                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                       |  | 21g. I certify that (I) (this hospital) attended the deceased from 8/5/82, to 8/7/82, that (I) (we) lost saw the deceased alive on 8/7/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 21h. SIGNATURE<br>Mark Carol |  | 21i. DATE SIGNED<br>8/7/82            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 21d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21e. ADDRESS   |  | 21f. UMD - Univ. Hospital   |  | 21g. 21223  |  | 21h. 21223                   |  | 21i. 21223                            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 21d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21e. ADDRESS   |  | 21f. UMD - Univ. Hospital   |  | 21g. 21223  |  | 21h. 21223                   |  | 21i. 21223                            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 21d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21e. ADDRESS   |  | 21f. UMD - Univ. Hospital   |  | 21g. 21223  |  | 21h. 21223                   |  | 21i. 21223                            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 21d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21e. ADDRESS   |  | 21f. UMD - Univ. Hospital   |  | 21g. 21223  |  | 21h. 21223                   |  | 21i. 21223                            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 21d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21e. ADDRESS   |  | 21f. UMD - Univ. Hospital   |  | 21g. 21223  |  | 21h. 21223                   |  | 21i. 21223                            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 21d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21e. ADDRESS   |  | 21f. UMD - Univ. Hospital   |  | 21g. 21223  |  | 21h. 21223                   |  | 21i. 21223                            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 21d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21e. ADDRESS   |  | 21f. UMD - Univ. Hospital   |  | 21g. 21223  |  | 21h. 21223                   |  | 21i. 21223                            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 21d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21e. ADDRESS   |  | 21f. UMD - Univ. Hospital   |  | 21g. 21223  |  | 21h. 21223                   |  | 21i. 21223                            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 21d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21e. ADDRESS   |  | 21f. UMD - Univ. Hospital   |  | 21g. 21223  |  | 21h. 21223                   |  | 21i. 21223                            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 21d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 21e. ADDRESS   |  | 21f. UMD - Univ. Hospital   |  | 21g. 21223  |  | 21h. 21223                   |  | 21i. 21223                            |  |
| 21a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21b. ADDRESS  |  | 21c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN                                       |  |  |  |  |  |   |  |   |  |                              |  |                                       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR STATE REGISTRAR   |  | Alice Rivers   |  | STATE OF MARYLAND   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                             |  | 8 2 20808   |  | CERTIFICATE OF DEATH                         |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR                               |  |
| Alice   |  | Rivers   |  |   |  |   |  | 8   |  | 2 82   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS                           |  |
| Female  |  | B/K  |  | August 12, 1910   |  | 71  |  | YRS.  |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  | 11. KIND OF BUSINESS OR INDUSTRY             |  |
| N. Carolina   |  | U.S.A.   |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | Baltimore City  |  | homemaker   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |  |  |
| Baltimore   |  | So. Baltimore General  |  |   |  |   |  |   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |  |  |
| Md.   |  |  |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 633 Asquith St., Apt 9D   |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)             |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS                                      |  |
| Salbury   |  | Cooper   |  | NO  |  | 220 34 6517   |  | Mardis Cooper P.O. Box 151  |  | Warrenton, N. Carolina                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4275  |  | Cardiorespiratory Arrest   |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
| Chronic granulocytic leukemia   |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED  |  |   |  |   |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  | P.M. 19   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  |   |  |   |  |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | STREET  |  | CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 8-2, 19 82, to 8-2, 19 82, that (1) (we) lost saw the deceased alive on 8-2, 19 82, and that (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death. |  | 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED  |  |   |  |  |  |
|   |  | M. Nestor  |  | M.D.  |  | 8-2-82  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                     |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION                                |  |
| M. Nestor   |  | 3001 S. Hanover, Balt. MD.   |  | Burial  |  | 8/8/82  |  | Greater Lovely Hill Macon Warren Co. N.C.                           |  | CITY OR TOWN                                 |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |  |  |
| George J. Gonce 4001 Ritchie Hgwy   |  | AUG 10 1982  |  | John J. Conner  |  |   |  |   |  |  |  |

Alice Rivers

8/12

N.A.A.

Co. Baltimore General

Letter

Cooper

220 34 417 Eddie Cooper P.O. Box 121

Edinburgh, Scotland

X

M.D.

3001 - Howard, Balt. Md.

8/12/25 Greater Society Hill Road, Arden Co. Md.

1925

Source: J. Edgar Hoover 1001 Rivers in New



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner must be notified.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 0 9

REG. NO.

|  |  |  |   |   |                            |   |   |
|--|--|--|---|---|----------------------------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM AKA WILLIE ROAF ROAF</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 21, 1982</b> |   | 2b. HOUR<br><b>5:30 pm</b> |   |   |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC 15, 1901</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOME Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 13e. STREET ADDRESS<br><b>1937 HERBERT ST</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RICHARD ROAF</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BETTIE ROAF</b>   |                            |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>W.W.I</b>   |   | 17. INFORMANT<br><b>Mrs. Lucinda Grover</b>   |                            | ADDRESS<br><b>1937 HERBERT ST</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 MYOCARDIAL INFRACTION</b><br>IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |   |                            |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>HYPERTENSION</b>  |  |  |   |   |                            |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                            |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 23</b> , 19 <b>82</b> , to <b>AUGUST 21</b> , 19 <b>82</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>AUGUST 21</b> , 19 <b>82</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death. |  |  |   |   |                            |   |   |
| 22b. SIGNATURE<br><b>George Thomas</b>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                            | 22c. DATE SIGNED<br><b>8/21/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE THOMAS MD</b>   |  |  |   | 22e. ADDRESS<br><b>CHURCH HOME CORP<br/>100 N. BROADWAY BALTIMORE, MARYLAND, 21231</b>  |                            |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8-23-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NATION CEM</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Londondown Baltimore, MD</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Sandra L. Russ 2222 W. NORTH AVE</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 25 1982</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelley</b>  |   |

80

1771

1772



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 2 0 8 1 0  |  |
|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |
| DR. MARTIN A. ROBBINS   |  |  |  | MONTH DAY YEAR   |  |
|   |  |  |  | THURS. AUG. 5, 1982  |  |
| 3. SEX  |  |  |  | 2b. HOUR   |  |
| MALE  |  |  |  | 10:30 AM   |  |
| 4. RACE   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| WHITE   |  |  |  | 64   |  |
| 5. DATE OF BIRTH  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>        |  |
| FEB. 26, 1918   |  |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| NEW JERSEY  |  |  |  | BALTIMORE CITY   |  |
| 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| USA   |  |  |  | UROLOGIST  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| BALTIMORE   |  |  |  | MEDICINE   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |  |  |  |  |
| 28 PALMER GREEN (21210)   |  |  |  |  |  |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY                              |  | 13c. CITY OR TOWN  |  |
| MARYLAND  |  |  |  | BALTIMORE  |  |
| 14. FATHER'S NAME (TYPE OR PRINT)   |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| CHARLES RABINOVITZ  |  | MATHILDA JACOBSON                        |  | 13e. STREET ADDRESS  |  |
|   |  |  |  | 28 PALMER GREEN (21210)  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WWII ARMY   |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO. 216-14-4990  |  |  |  |  |  |
| 17. INFORMANT ADDRESS MRS. MARGY ROBBINS 28 PALMER GREEN (21210)  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT Brain Tumor  |  |  |  |  |  |
| 1919 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |  |  |
| 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1981, to Aug 5, 1982, that (I) saw the deceased alive on Aug 1, 1982, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) |  |  |  |  |  |
| 22b. SIGNATURE Albert J. Himelef M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |  |  |
| 22c. DATE SIGNED 8/5/82   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT J. HIMELEF M.D.  |  |  |  |  |  |
| 22e. ADDRESS 2435 W. Belvedere Ave  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL  |  |  |  |  |  |
| 23b. DATE 8-6-82  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW   |  |  |  |  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN, BALTO, MD.  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)  |  |  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR AUG 10 1982   |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE John J. Carver   |  |  |  |  |  |

ATTACHED

SECRET

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 1 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET E. ROBERTS</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8/25/82</b>   |   | 2b. HOUR<br><b>8:12 AM</b>   |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>NEGRO</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-12-99</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                              |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Va.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balt City</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b> |
| 13a. STATE<br><b>MD.</b>  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1706 E. Oliver St.</b>                               |   |
| 14. FATHER'S NAME<br>(FIRST) <b>Charles</b> (MIDDLE) <b>Boothe</b> (LAST) <b>Boothe</b>   |   | 15. MOTHER'S MAIDEN NAME<br>(FIRST) <b>Margaret</b> (MIDDLE) <b>Bowman</b> (LAST) <b>Bowman</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>214-26-3086</b>  |   | 17. INFORMANT<br><b>Marguerite Blue</b> ADDRESS <b>4916 Alhambra Ave.</b>      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br><b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic Renal Failure, Decubitus Ulcer</b>  |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (i) (this hospital) attended the deceased from <b>8/25</b> to <b>8/25</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.  |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Manuel B. Galicia Jr.</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>8/25/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARCOS B. GALICIA JR. MD</b>  |   | 22e. ADDRESS<br><b>North Charles Gen Hosp.</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>REMOVED</b>  |   | 23b. DATE<br><b>8-28-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Emanuel Baptist Ctry. Smithfield</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Va.</b>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Randolph J. Callick 2431 E. Oliver St.</b>   |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 26 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their plates remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

item 7a #G570 8/31/82 ph

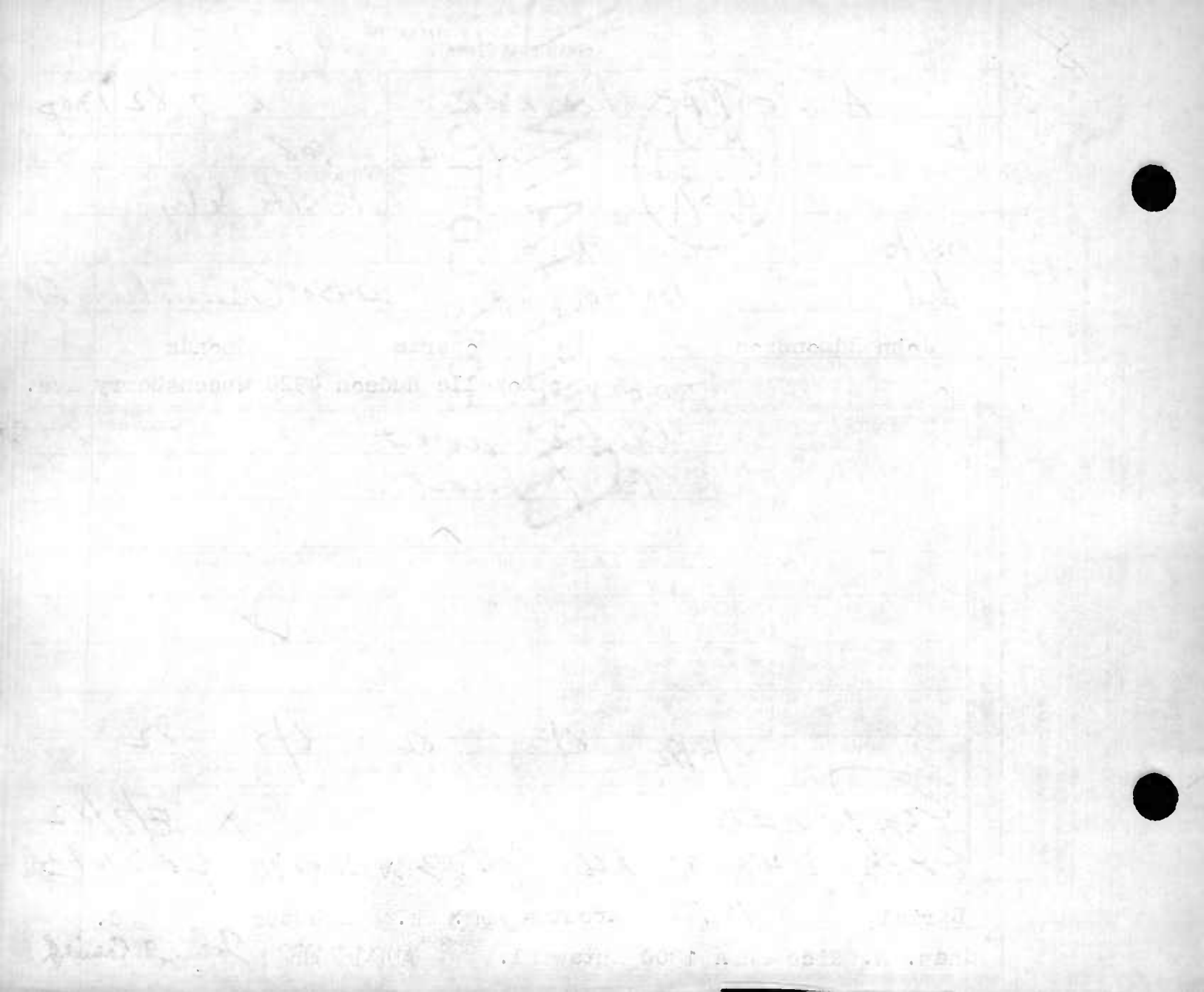
FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 1 2

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNIE MAE ROBINSON.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 7 82</b>  |  | 2b. HOUR<br><b>130 PM</b>  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>N</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 24 14</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>  |  | 7. UNDER 1 YEAR<br>WOMEN DAYS MEN  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NONE, GIVE FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   | 13b. COUNTY<br><b>Balto</b>  | 13c. CITY OR TOWN<br><b>Balto</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>4950 Queensberry Ave.</b>                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Edmondson</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Roberta Edmonds</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-07-8368</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mozelle Hudson 4920 Queensberry Ave.</b>              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>On of heart.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>1. WHILE AT WORK <input type="checkbox"/> 2. WHILE NOT AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/3/82</b> to <b>8/7/82</b> that (I) (we) last saw the deceased alive on <b>8/3/82</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Edmondson</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>8/7/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDWARD HANCO KID</b>  |  | 22e. ADDRESS<br><b>3473 Arbutus Rd 20043</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>8/13/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. A. Rice FHPA 1300 Eutaw Pl.</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 17 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Givens</b>  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the body must be examined.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 0 8 1 3  |  |  |  |
|---|--|---|--|--|--|--|--|
| FOR<br>1 - STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Delores ROBINSON</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 18, 1982</b>  |  | 2b. HOUR<br><b>9:40a M</b>   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Negro</b>                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT 9 1932</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>               |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Govt Worker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Govt</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  |  |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 13e. STREET ADDRESS<br><b>3600 ULMAN AVE</b>  |  |   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE CHARLIE</b>  |  |  |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ERMA BLACKSTON</b>  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Lena Smith 3600 ULMAN AVE</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1991</b><br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest, secondary to pneumonia.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Terminal adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11b.  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 3</b> , 19 <b>82</b> , to <b>August 18</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>August 18</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Mohammad Aslam M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/18/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mohammad Aslam, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/21/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn Md</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph L. Russ 2222 W. North Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 25 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the vital records death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner will be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 8 2 2 0 8 1 4                                      |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LEROY ROBINSON</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 20 82</b> |  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 20 26</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>56</b>  |  | 2b. HOUR<br><b>8:20 P M</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Post Office</b>  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3202 Phelps Lane</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Dorothy Bailey</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-18-7243</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Dorothy Robinson</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1579 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma Pancreas &amp; Metastases</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-20</b> , 19 <b>82</b> , to <b>8-20</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8-20</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Rosita R. Cruz M.D.</b>  |  |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>           |  |  |  | 22c. DATE SIGNED<br><b>8/20/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROSITA R. CRUZ M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSPITAL</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/25/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville Vet.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>A.A. Co. MD</b>                                |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leroy O. Dyett</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 23 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Sam E. Carver</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 20815  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>NAOMI R. ROBINSON  |  |  |  | 2b. HOUR 8 18 82 2346 M   |  |   |  |
| 3. SEX FEMALE  |  | 4. RACE WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 13 23  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY ---   |  |
| 13a. STATE Md  |  |  |  | 13b. CITY OR TOWN Arbutus   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William R. Daniels  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rose Beckman  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |  |  | 16b. SOCIAL SECURITY NO. 215-16-2758  |  | 17. INFORMANT ADDRESS<br>Robert C. Mason 643 S. Wickham Rd., 21229  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>4029 IMMEDIATE CAUSE (a) Cardio - Pulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Hypertension, Diabetes mellitus<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-18-82 to 8-18-1982, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE R. Machado MD.  |  |  |  | DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED 8/18/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Machado MD  |  |  |  | 22e. ADDRESS St Agnes Hosp. Balto. Md.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 08-23-82   |  | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland   |  |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 21229 AUG 20 1982   |  | 25b. REGISTRAR'S SIGNATURE John J. Carver   |  |

5-2-103

STANDARD TIME  
STANDARD TIME





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |                                    |  |  |  |
|--|--|--|--|---|--|--|--|--|------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THOMAS</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 4, 1982</b> |  |  |  |                                    | 2b. HOUR<br><b>7:38p<sub>M</sub></b>                           |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 16 08</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                    | IF UNDER 74 HRS.<br>HOURS MIN.                                 |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                            |  |  |                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Md. State Lottery</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD</b>  |  |  |  | 13b. COUNTY<br><b>Carroll</b>   |  | 13c. CITY OR TOWN<br><b>Hampstead</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    | 13e. STREET ADDRESS<br><b>315 Hanover Pike</b>                 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Lawrence Roche</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie G. Vallee</b>   |  |  |  |  |                                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>W.W. II 213-01-4985</b>  |  | 17. INFORMANT<br><b>Susan M. Roch</b>  |  |  | ADDRESS<br><b>315 Hanover Pike</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br><b>2762 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u></b>   |  |  |  |   |  |  |  |  |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b> |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>marked lactic acidosis</b>  |  |  |  |   |  |  |  |  |                                    | <b>hours</b>   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>septic shocks vs. acute hepatic failure</b>   |  |  |  |   |  |  |  |  |                                    | <b>hours</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><b>severe myeloid metaplasia / myelofibrosis &amp; dysmyelosis syndrome</b>   |  |  |  |   |  |  |  |  |                                    |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |                                    |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/20</b> , 19 <b>82</b> , to <b>8/4</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8/4</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |                                    |  |  |  |
| 22b. SIGNATURE<br><b>John Mannisi MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                    | 22c. DATE SIGNED<br><b>8/4/82</b>                              |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Mannisi MD</b>  |  |  |  | 22e. ADDRESS<br><b>600 N. Wolfe St Balt MD 21205</b>  |  |  |  |  |                                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Aug 6 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                           |  |  |                                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James B. Eckhardt</b>   |  |  |  | ADDRESS<br><b>11605 Reisterstown Rd</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 9 1982</b>   |  |  |                                    |  |  |  |

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NOTION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |         |  |   |                                    |  |  |  |   | 8 2 2 0 8 1 7<br>REG. NO.   |                                   |  |
|--|--|---------|--|---|------------------------------------|--|--|--|---|---|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         | FIRST MIDDLE LAST  |   |                                    | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  | 2b. HOUR  |   |                                   |  |
| John F. Rocoski  |  |         |  |   |                                    | August 16, 1982  |  |  | 7:40 A.M.   |   |                                   |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH MONTH DAY YEAR                                     |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. UNDER 1 YEAR MONTHS DAYS  |   | 8. UNDER 72 HRS. HOURS MIN.   |                                   |  |
| Male   |  | White   |  | September 7, 1902   |                                    | 79 YRS.  |  |  |   |   |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |   |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |                                   |  |
| Pennsylvania   |  |         | USA  |   |                                    |  |  |  | Baltimore City MD.  |   |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                    |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore  |  |         | 4828 Williston Street  |   |                                    |  |  |  | Retired Stockman  |   | U.S. Government                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |         |  |   |                                    |  |  |  |   |   |                                   |  |
| 13a. STATE   |  |         | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |   |                                   |  |
| Maryland   |  |         | ---  |   | Baltimore                          |  |  |  | 4828 Williston Street   |   |                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |         |  |   |                                    | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |   |   |                                   |  |
| (unknown)  |  |         |  |   |                                    | Rocoski Mary (unknown)   |  |  |   |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES  |  |         |  | 16b. SOCIAL SECURITY NO.  |                                    | 17. INFORMANT ADDRESS  |  |  |   |   |                                   |  |
| No   |  |         |  | 203-05-1824   |                                    | Mrs. John F. Rocoski Same As # 13  |  |  |   |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.  |  |         |  |   |                                    |  |  |  |   |   |                                   |  |
| 1509 IMMEDIATE CAUSE (a) <i>Coronary of Esophagus</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>   |  |         |  |   |                                    |  |  |  |   |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |         |  |   |                                    |  |  |  |   |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |         |  |   |                                    |  |  |  |   |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |         |  |   |                                    |  |  |  |   |   |                                   |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)   |  |  |   |   |                                   |  |
|  |  |         |  | P.M. 19   |                                    |  |  |  |   |   |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |                                   |  |
|  |  |         |  |   |                                    |  |  |  |   |   |                                   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>Sept</i> , 19 <i>68</i> , to <i>August</i> , 19 <i>82</i> , that (he) (she) (it) last saw the deceased alive on <i>8-11-82</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not see the body after death, so state.) |  |         |  |   |                                    |  |  |  |   |   |                                   |  |
| 22b. SIGNATURE DEGREE  |  |         |  |   |                                    | 22c. DATE SIGNED   |  |  |   |   |                                   |  |
| <i>Nelson J. McKay M.D.</i>  |  |         |  |   |                                    | <i>8/17/82</i>   |  |  |   |   |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |         |  |   |                                    | 22e. ADDRESS   |  |  |   |   |                                   |  |
| Nelson J. McKay M.D.   |  |         |  |   |                                    | 1132 N. Rolling Rd. Baltimore, Md. 21228   |  |  |   |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK)  |  |         | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                |   |   |                                   |  |
| Burial   |  |         | 8/21/82  |   | St. Marys Cemetery                 |  |  | Wilkes-Barre Pa.   |   |   |                                   |  |
| 24. FUNERAL DIRECTOR NAME  |  |         |  |   |                                    | 25a. DATE REC'D. BY (TYPE OR PRINT)  |  |  | 25b. SIGNATURE  |   |                                   |  |
| Witzke Funeral Home  |  |         |  |   |                                    | AUG 17 1982  |  |  | <i>John J. Coniff</i>   |   |                                   |  |
| 1630 Edmondson Avenue, Catonsville, Md. 21228  |  |         |  |   |                                    |  |  |  |   |   |                                   |  |

John F. Kennedy Library

October 7, 1963

Dear Mr. Kennedy:  
I am very pleased to hear from you and to learn that you will be visiting the United States soon. I am sure that your visit will be a most fruitful one and that you will have a very enjoyable trip.

I am sure that your visit will be a most fruitful one and that you will have a very enjoyable trip. I am sure that your visit will be a most fruitful one and that you will have a very enjoyable trip.

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item #G571 9/15/82 ph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 1 8

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |  |  |   |  |   |
|--|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WALTER VIVIAN ROE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8/27/82</b>   |  | 2b. HOUR<br><b>7:45 AM</b>  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 01 99</b>                  |   | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Woodlawn</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)<br><b>late Samuel H. Roe</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)<br><b>Not Known</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-03-1213</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs Mary Roe 2209 Lukewood Dr 21207</b>               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4275 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary edema, pneumonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>fx, dislocation C5-6</b>  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 21</b> , 19 <b>82</b> , to <b>Aug 27</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Aug 21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |
| 22b. SIGNATURE<br><b>Ted W. Switzer, M.D.</b>  |  | DEGREE   |   | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TED WESLEY SWITZER, M.D.</b>   |  | 22e. ADDRESS   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>Aug 30, 1982</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>                           |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry H Witzke</b>  |  | ADDRESS<br><b>4112 Columbia Rd Ellicott City</b>                       |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 30 1982</b>                                  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  | 25c. REGISTRAR'S NAME<br><b>John J. Conner</b>                         |   |  |   |
| 25d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |  |   |  |   |

MEDICAL CERTIFICATION

2  
9

83

83

2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner may be requested to autopsify the body.





item 5,0 #G571 9/27/82 ph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 1 9

REG. NO.

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>COLEMAN ROGERS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 21, 1982</b>   |  | 2b. HOUR<br><b>1:00PM</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-25-11</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS<br>MONTHS DAYS HOURS MIN            | IF UNDER 1 YEAR<br>IF UNDER 24 HRS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARION Co. S.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance Engineer</b>                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>South Carolina</b>   |  | 13c. CITY OR TOWN<br><b>Dillon</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS<br><b>108 Hardy Street</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmore Rogers</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sisley Davis</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b> |  |   |
| 16b. SOCIAL SECURITY NO.<br><b>249-10-9220-A</b>  |  | 17. INFORMANT<br><b>Flora Mae Rogers</b> ADDRESS<br><b>108 Hardy Street</b>  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1850 IMMEDIATE CAUSE (a) pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>carcinoma of the prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>metastases to spine</b>   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>1 year</b><br><b>2 months</b>                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/1</b> , 19 <b>82</b> , to <b>8/21</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. |  |  |   |  |   |
| 22b. SIGNATURE<br><b>H. LANGEVIN</b>  |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8/21/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. LANGEVIN</b>   |  | 22e. ADDRESS<br><b>OSLER 3, JOHNS HOPKINS HOSP.</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CITY)<br><b>BURIAL</b>  | 23b. DATE<br><b>8-29-82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. James Ame Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Marion South Carolina</b>           |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William J. Spicer 1639 N. Broadway</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 24 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canineh</b>                                 |   |

After made notified

3

MEDICAL CERTIFICATION

229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer must be notified.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

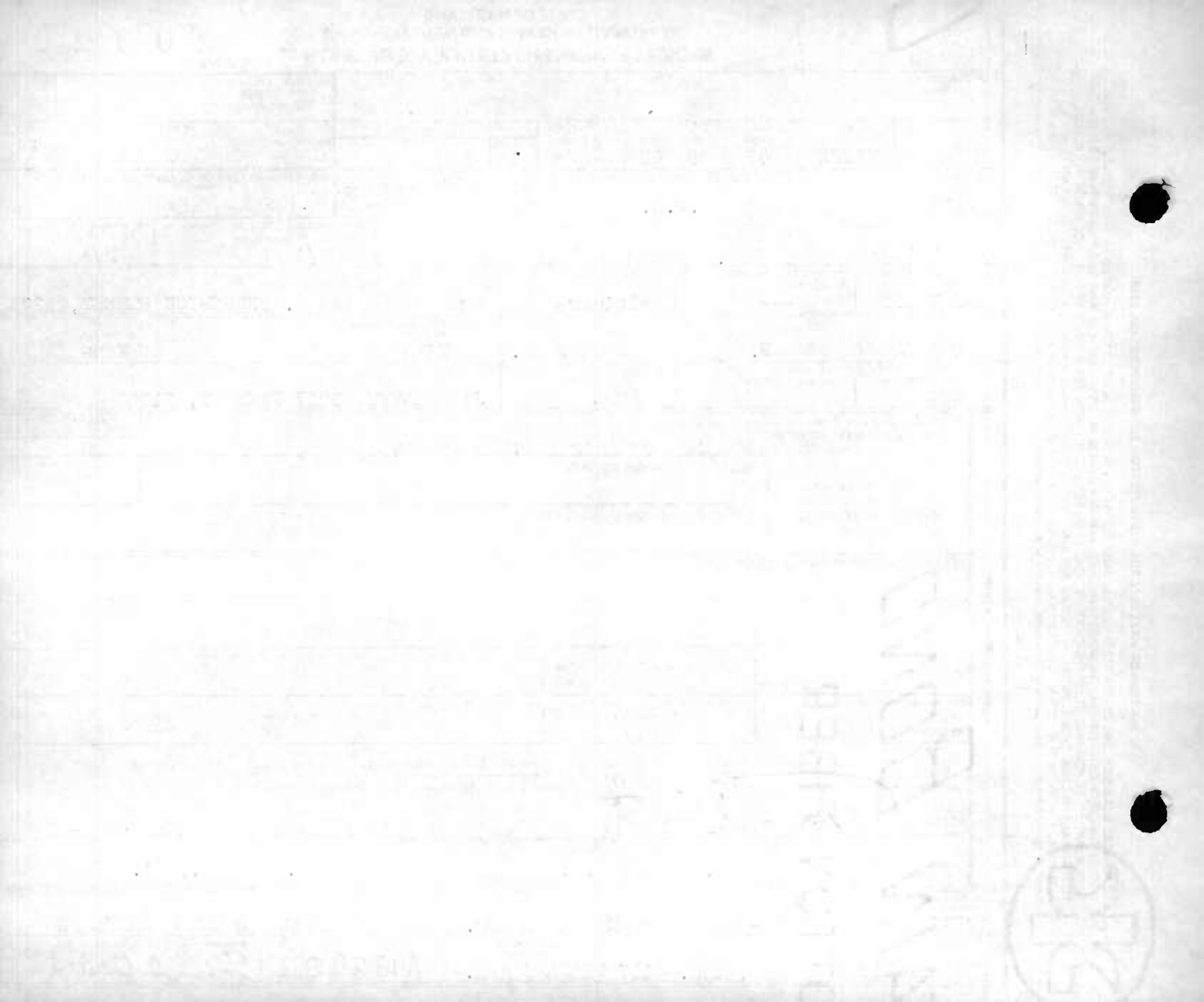
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |  |  |   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
|--|---------|--|--|---|--|---|--|--------------------------------|--|--------------------------------|--|-------|--|-----|--|------|--|-------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH     |  | ESTI-<br>MATED                 |  | MONTH |  | DAY |  | YEAR |  | 2b. HOUR    |  |
| DONALD   |         | F.   |  |   |  | ROGERS, JR.   |  | 8                              |  | 25                             |  | 19    |  | 82  |  |      |  | M           |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.               |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH |  | DAY |  | YEAR |  | 2d. HOUR    |  |
| MALE   | WHITE   | 07 08 82   |  | YRS.  |  | 1 17  |  | MIN.                           |  | 8                              |  | 25    |  | 19  |  | 82   |  | 4:27<br>a M |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| MARYLAND   |         | U.S.A.   |  |   |  | Baltimore City  |  |                                |  |                                |  |       |  |     |  |      |  | MD.         |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| Baltimore  |         | St. Agnes Hospital   |  | N/A   |  | N/A   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS            |  |                                |  |       |  |     |  |      |  |             |  |
| MARYLAND   |         | ---  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 445 S. BRUNSWICK STREET, 21223 |  |                                |  |       |  |     |  |      |  |             |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| DONALD   |         | TINA   |  |   |  |   |  |                                |  |                                |  |       |  |     |  |      |  | KING        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| N/A  |         | NONE   |  | JIM BEATTY  |  | 3017 FREEWAY, 21227   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>7980 IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         |  |  |   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
|  |         |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .   |         |  |  |   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)  |  | DATE SIGNED   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| Thomas D. Smith, M.D.  |         | M.D. Deputy Chief  |  | 8-25-82   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  |   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
|  |         | 111 Penn St., Balto., Md. 21201  |  |   |  |   |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| BURIAL   |         | 08-27-82   |  | MEADOWRIDGE MEM. PARK   |  | ELKRIDGE HOWARD MARYLAND  |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                |  |                                |  |       |  |     |  |      |  |             |  |
| HUBBARD FUNERAL HOME, INC.   |         | 4107 WILKENS AVE.  |  | AUG 26 1982   |  | John J. Canfield  |  |                                |  |                                |  |       |  |     |  |      |  |             |  |

2005 BP



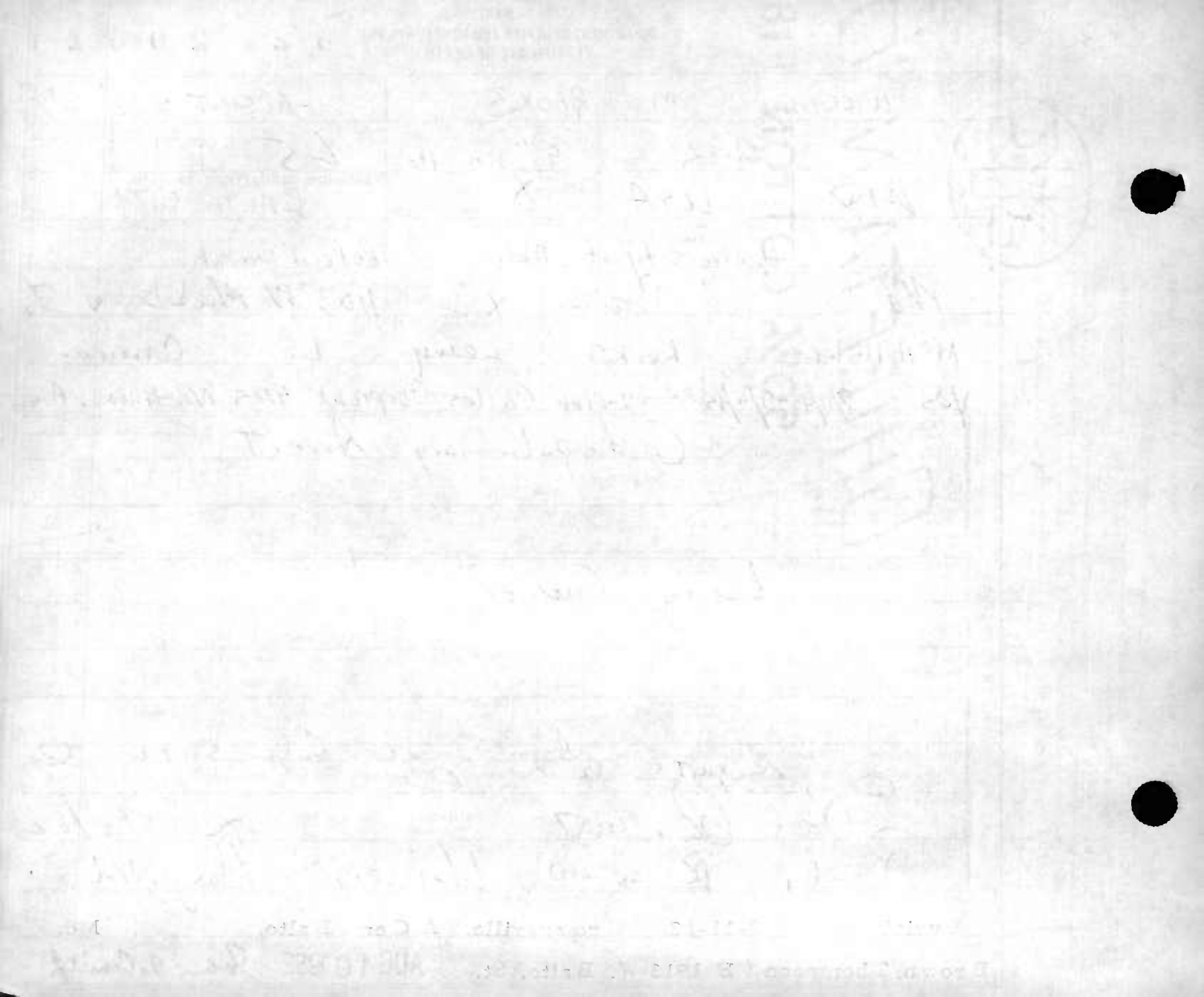
NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO: FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | REG. NO. 82 20821  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR PM  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>WILLIAM M ROOKS   |  |  |  |   |  | AUGUST 5 82  |  |  |  | 2 PM   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 16 16   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD                                 |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Md. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Steelwk. |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE MD 13c. COUNTY   |  | 13d. CITY OR TOWN<br>Balto.  |  | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13. STREET ADDRESS<br>1103 W Phil L Berry St.  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>McAllister Rooks  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Leamy L. Choice  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>7/1743-9/1645   |  | 17. INFORMANT ADDRESS<br>Calles Corprew 4705 Northwood Ave.                          |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Lung Cancer   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 5, 1982, to August 5, 1982, that (I) (we) last saw the deceased alive on August 5, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Paul Rivas MD   |  |  |  | DEGREE<br>MD  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>8/5/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul Rivas MD  |  |  |  | 22e. ADDRESS<br>University Hospital   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>8-11-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crownsville V A Cem                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Brown/Thompson FH 1913 W. Balto. St.  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 10 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine   |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 2 2

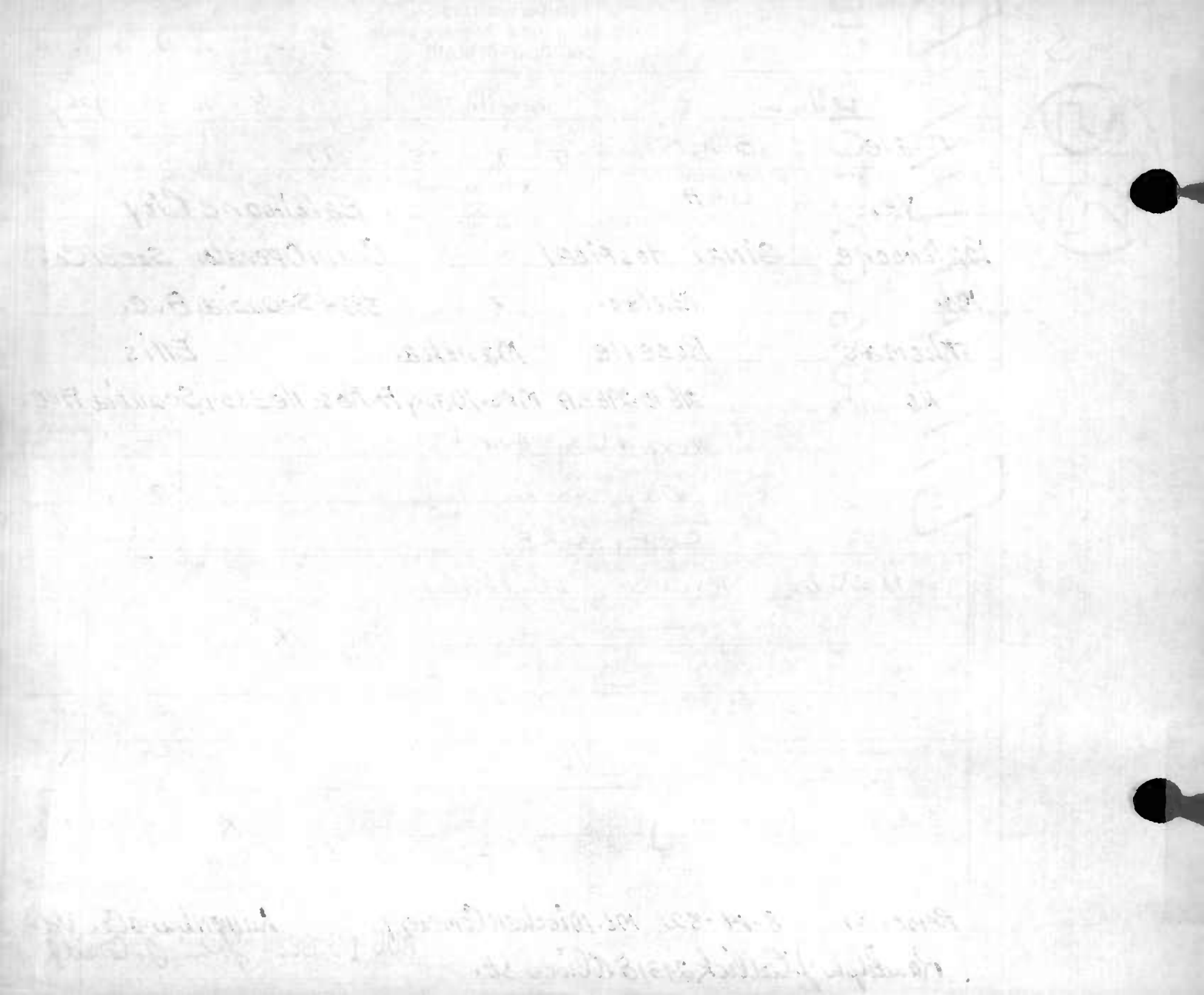
REG. NO.

|  |                                     |  |  |  |  |
|--|-------------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR   |                                     | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William J Roselle   |                                     | MONTH DAY YEAR<br>8 10 82  |  | 926 P.M.   |  |
| 3. SEX<br>male   | 4. RACE<br>BLACK                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 9 05   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sina Hospital  |  | 12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE)<br>Chain Operator                      |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Co.   |                                     | 13a. STREET ADDRESS<br>3834 Sequoia Ave.   |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  |
| 14. FATHER'S NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Thomas Roselle   |                                     | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Martha Ellis  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |  |
| 17. INFORMANT<br>Mrs. Mary A. Roselle  |                                     | 18. SOCIAL SECURITY NO.<br>26-10-2963A   |  | 19. ADDRESS<br>3834 Sequoia Ave.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>4280<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pneumonia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>C.H.F., C.R.F.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 days<br>Chronic |                                     |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>Diabetes, ASCVD, Atrial fibrillation</u>  |                                     |  |  |  |  |
| 19a. DATE OF OPERATION<br>—  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                     | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>—  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — — 19 —                                   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—  |                                     | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> —   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—                           |  |
| 21f. LOCATION<br>STREET<br>—   |                                     | 21g. CITY OR TOWN<br>—   |  | 21h. COUNTY<br>—   |  |
| 21i. STATE<br>—  |                                     | 22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/79</u> , 19 <u>82</u> , to <u>8/10</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/1/79</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Edward Zimmerman   |  |
| 22c. DATE SIGNED<br>8/10/82  |                                     | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Edward Zimmerman  |  | 22e. ADDRESS<br>Sina Hospital of Balt  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |                                     | 23b. DATE<br>8-14-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Mitchell Cemetery  |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Luganburg Co. Va.   |                                     | 23e. COUNTY<br>—   |  | 23f. STATE<br>—  |  |
| 24. FUNERAL DIRECTOR<br>Randolph J. Collick  |                                     | 24a. ADDRESS<br>24318 Oliver St.   |  | 24b. DATE OF RECORD<br>AUG 15 1982   |  |
| 24c. REGISTRAR'S SIGNATURE<br>John J. Conner   |                                     | 24d. COUNTY<br>—   |  | 24e. STATE<br>—  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and signed.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 2 3

REG. NO.

|  |  |   |  |   |  |  |  |   |
|--|--|---|--|---|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | 2a. DATE OF DEATH  |   |  | 2b. HOUR   |  |   |
| Mary H. Rowan  |  |   | August 1, 1982   |   |  | 2:30 M   |  |   |
| 3 SEX  | 4 RACE   | 5 DATE OF BIRTH   | 6 AGE (IN YEARS LAST BIRTHDAY)   |   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |
| Female   | White  | May 28, 1894  | 88 YRS   |   |  | MONTHS DAYS  |  | HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |  |   |
| Maryland   | U.S.A.   |   |  | Baltimore City MD.  |  |  |  |   |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| Baltimore  | St. Agnes Hospital   |   |  | Sec. - Treas.   |  | Rowan Controller   |  |   |
| 13a. STATE   |  |   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS  |  |   |
| Maryland   |  |   | City   | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 1105 Ramble Wood Rd.   |  |   |
| 14 FATHER'S NAME   |  |   | 15 MOTHER'S MAIDEN NAME  |   |  |  |  |   |
| John Howard Rowan  |  |   | Margaret Sisselberger  |   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.   |   | 17 INFORMANT   |  |  |   |
| NO   |  |   | 214-03-1626  |   | 4501 Old Frederick Rd. Balto., MD.<br>Uplands Home for Church Women            |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>Cerebral vascular accident</u>                          |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>10 days</u><br><u>26 days</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |   |  |   |  |  |  |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                    |
|  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |   |
|  |  |   | P.M. 19  |   |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |
|  |  |   |  |   |  |  |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (this) did not view the body after death. |  |   |  |   |  |  |  |   |
| 22b. SIGNATURE<br><u>Gregory E. Mc Auliffe MD</u>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>8.1.82  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gregory E. Mc Auliffe   |  |   |  |   |  | 22e. ADDRESS<br>St. Agnes Hospital Caton Ave., Balto., Md.   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |
| Burial   |  |   | 8-4-1982   |   | Loudon Park Cemetery   |  | Baltimore City MD.                         |   |
| 24. FUNERAL DIRECTOR<br>LARRY M. & RUSSELL C. WITZKE FUNERAL HOME P.A.<br>1630 Edmondson Ave., Catonsville, MD.  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG - 2 1982  |  |   |

May 28, 1982

Female

U.S.A.

St. Anne's Hospital

1900 Randle Wood St.

Howard

210-0-0000

210-0-0000

210-0-0000

210-0-0000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 0 8 2 4<br>REG. NO.   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Carmie V. Roy</i>  |  |  |  | 2b. HOUR<br><i>54. M</i>  |  |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>5 3 08</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hospital</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><i>3137 Belmont Avenue</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Arthor H. Lewis</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Ellen Sarah Jackson</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>N/A</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>N/A</i>   |  | 17. INFORMANT ADDRESS<br><i>Percy A. Roy 3137 Belmont Avenue</i>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>metastatic Cancer of lung &amp; Liver</i><br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/26/82</i> to <i>8/1/82</i> , that (I) (we) last saw the deceased alive on <i>7/31</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Moges G. Gorbemariam</i>   |  |  |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>8/1/82</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Moges G. Gorbemariam</i>  |  |  |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>8-6-82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary Cem.</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore Md.</i>  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Wm. C. March F/H 1101 E. North Avenue</i>   |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br><i>AUG - 3 1982</i>  |  |  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

RECEIVED  
JAN 10 1964

RECEIVED

JAN 10 1964

1/10/64

1/10/64

1/10/64

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health department. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

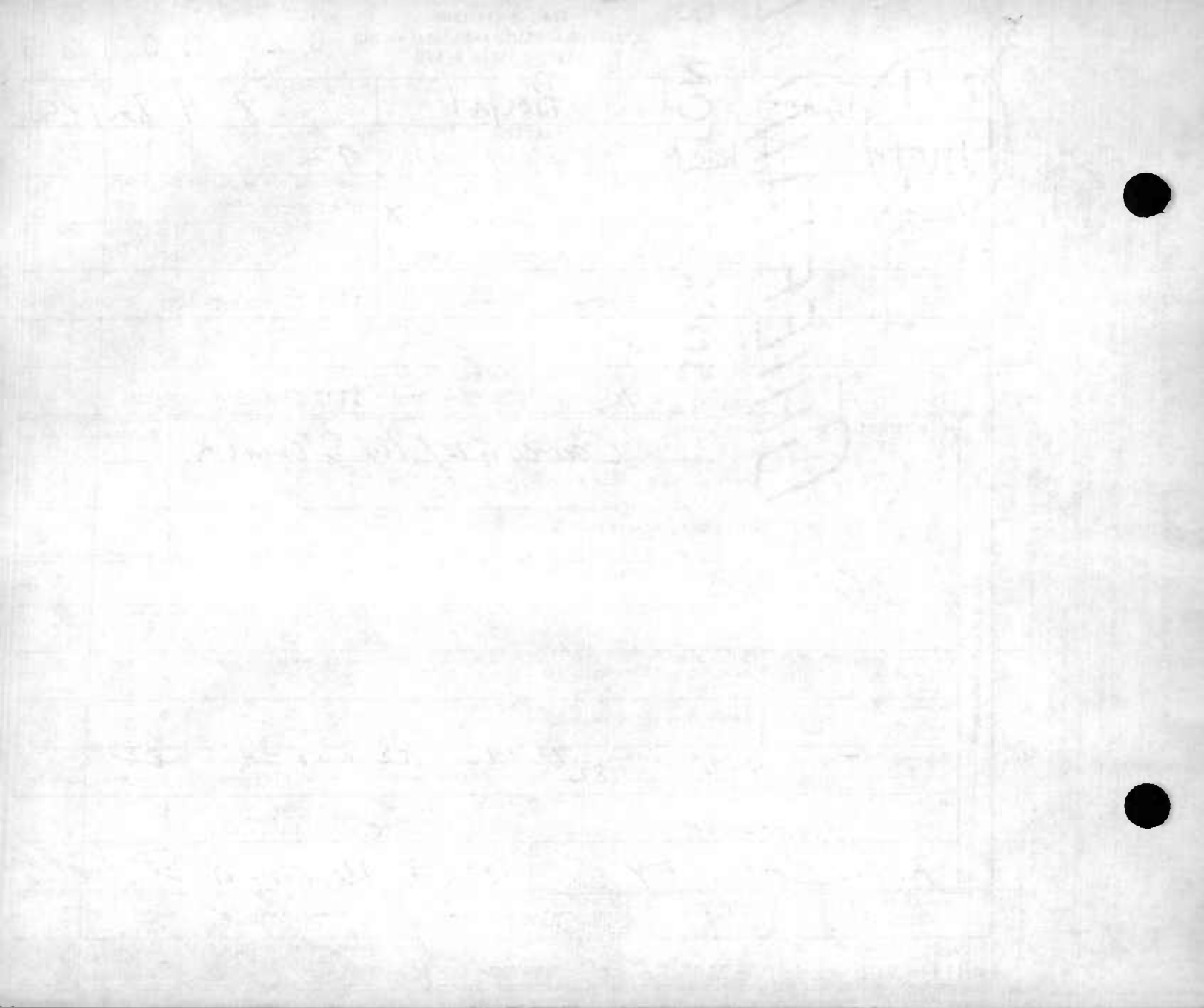
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 2 5

REG. NO.

|   |  |  |  |
|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES</b> FIRST <b>ROYAL</b> LAST  |  | 2a. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>4</b> YEAR <b>82</b> 2b. HOUR <b>1:05</b> PM                                    |  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>9</b> YEAR <b>1910</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  | 8. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.   |  | 10. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pennsylvania Ave Nursing Home</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>1711 Llewellyn Ave</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Archie</b> MIDDLE <b>ROYAL</b> LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b></b> LAST  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |  |
| 17. INFORMANT<br><b>Carrie Green</b>  |  | ADDRESS<br><b>1709 Llewellyn Avenue</b>  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1519 Cancer of the Stomach</b><br>IMMEDIATE CAUSE (a) <b>Cancer of the Stomach</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a<br><b>old stroke</b>   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDFRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF FURTHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-14</b> , 19 <b>82</b> , to <b>8-4</b> , 19 <b>82</b> that (I) (we) lost saw the deceased alive on <b>8-4</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |
| 22b. SIGNATURE<br><b>R. D. CADSLEY</b>  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. D. CADSLEY</b>   |  | 22e. ADDRESS<br><b>1235 E. Monument St Balto</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/9/82</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Calvary Cem</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Arundel</b> COUNTY <b>Co</b> STATE <b>Md</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>William C. March F/H 1101 E. North Avenue</b> ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1982</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>                          |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 2 0 8 2 6<br>REG. NO.   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA RUBIN</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>8-26-82</b>  |  |  |   |
| 3. SEX <b>FEMALE</b>   |  |  |  | 2b. HOUR <b>245<sup>PM</sup></b>  |  |  |   |
| 4. RACE <b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>OCT. 30 1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDAVE HEBREW GERIATRIC CENTER HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |   |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS ABRAMSON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH UNKNOWN</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |   |
| 16b. SOCIAL SECURITY NO.<br><b>213-34-3285</b>   |  | 17. INFORMANT <b>MRS. CAROLYN SCHERR</b><br><b>4005 STARBROOK RD. RANDALLSTOWN, MD 21133</b>   |  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b><br>5070<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>HRC.</b> |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (this hospital) attended the deceased from <b>9/5</b> , 19 <b>78</b> , to <b>8/26</b> , 19 <b>82</b> , that (we) last saw the deceased alive on <b>8/26</b> , 19 <b>82</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.  |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Estrelita O. Kru, MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>8/26/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ESTRELITA O. KRU, MD</b>   |  |  |  | 22e. ADDRESS<br><b>LEVINDAVE HEBREW GERIATRIC CENTER - HOSPITAL</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>AUG. 27, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE KURLAND KNESSETH ISRAEL</b>  |  | 23d. LOCATION<br><b>BALTIMORE MARYLAND</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 1 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |   |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a death certificate must be filed with the State Dept. of Health and Mental Hygiene.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 2 7  
REG. NO.

1. FOR  
STATE  
REGISTRAR

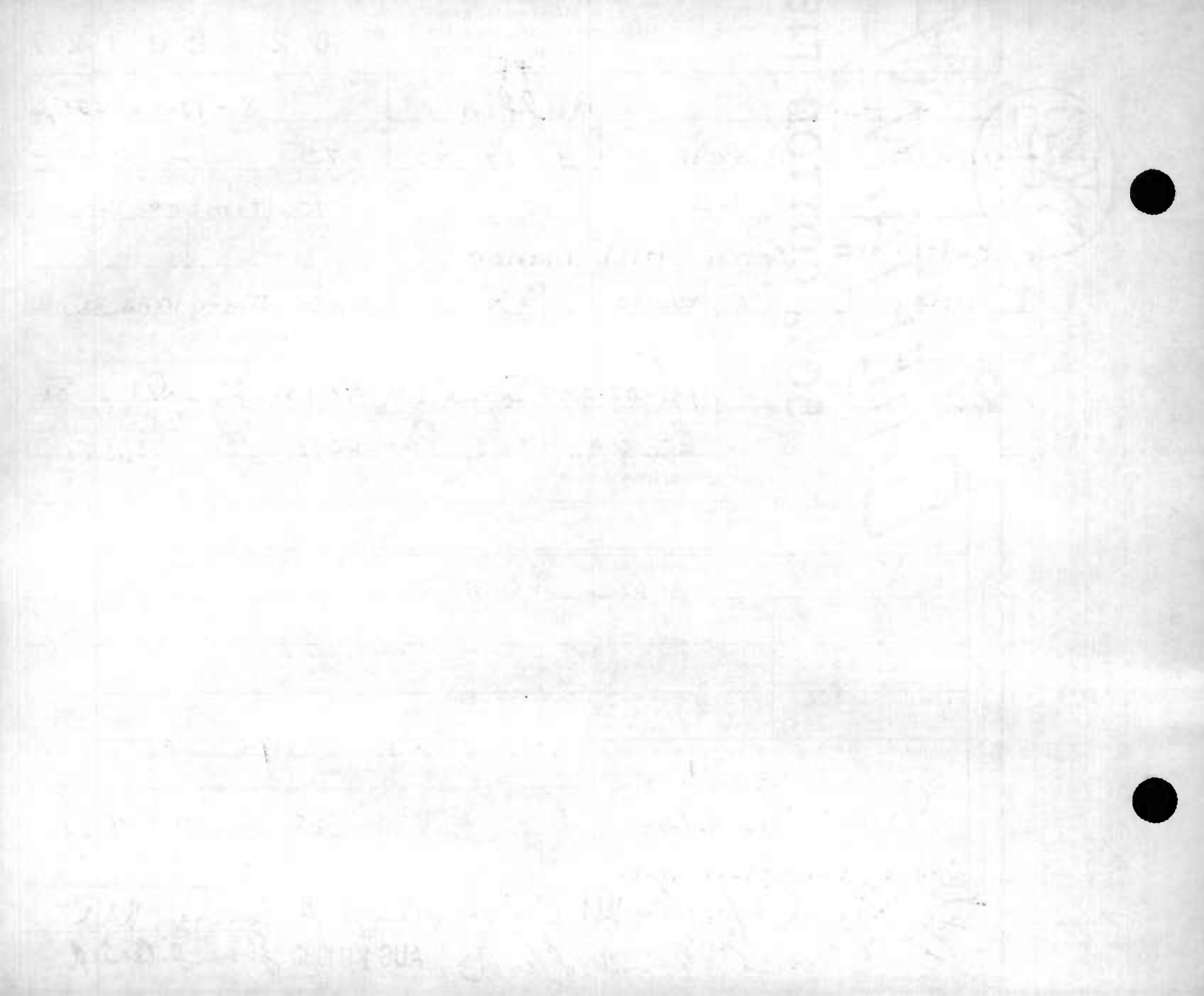
|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Harry Ruffin</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8-17-82</b>  |   | 2b. HOUR<br><b>2:45 PM</b>                                  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>Black</b>                   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 27 87</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>- - - -</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Seton Hill Manor</b>                        |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    | 12b. KIND OF BUSINESS OR INDUSTRY                           |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MD.</b> |   | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2200 Maryland ave</b>                     |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.<br><b>181-07-0777</b>  |   | 17. INFORMANT ADDRESS<br><b>Seton Hill Manor 501 W. Franklin St</b> |   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Concussion Head of Pancr</b><br><b>1570</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3/17/82</b> |
|--|--|--|

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Renal Insufficiency</b>  |  |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-1</b> 19 <b>82</b> to <b>3-17</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>3-17</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Jamie Punzalan</b>   | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>8/18/82</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jamie Punzalan M.D.</b>   |  | 22e. ADDRESS   |  |

|  |                             |  |  |
|--|-----------------------------|--|--|
| 23a. REMOVAL<br><b>Byrd</b>                              | 23b. DATE<br><b>8/21/84</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Charles</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>A A County, MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Carl 1912 W. York</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 19 1982</b>      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| Item #1 Film G570 8/27/82 rc  |  |  |  |   | REG. NO. 8 2 2 0 8 2 8                                    |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Louis Jules Joseph Ruland</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>August 18 1982</b> |  |  | 2b. HOUR<br><b>8:15 P M</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>July 1 1907</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Research Rep.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Merck, Sharpe &amp; Dohme</b>  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13c. STREET ADDRESS<br><b>3612 Buckingham Road</b>                                       |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Ruland</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lydia Sulzer</b>  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>082-05-2633</b>   |  | 17. INFORMANT <b>Mrs. Florence C. Ruland</b><br>ADDRESS <b>3612 Buckingham Rd., Baltimore, MD 21207</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Anterior Wall Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Elio Raul Novoa</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Elio Raul Novoa</b>   |  |  |  | 22e. ADDRESS  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/21/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore MD</b>               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors, Inc.</b><br>ADDRESS <b>8728 Liberty Rd., Randallstown, MD 21133</b>   |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>AUG 20 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Ganiel</b>                                      |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

DHMH - 16 50M 1/BI  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |               | 8 2 2 0 8   2 9<br>REG. NO.   |   |  |  |  |
|---|--|---|---------------|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST Howard  | MIDDLE Howard | LAST Ruley  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   | 2b. HOUR                                       |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |               | 5. DATE OF BIRTH  |   | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.      |
| BIRTHPLACE (STATE OR FOREIGN)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                            |  | MD.  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>City Hospitals |               |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Metallurgist |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Co. |
| 13a. STATE<br>Maryland  |  | 13b. CITY OR TOWN<br>Baltimore  |               | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13d. STREET ADDRESS<br>955 Martin Road 21221                                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Ruley   |  |   |               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rowena Hardie  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>218 18 0900   |               | 17 INFORMANT<br>ADDRESS<br>Agnes R. Cheatham 10 Parham Circle Apt. TB<br>Balto. Md. 21237   |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1991 IMMEDIATE CAUSE (a) Pulmonary Edema<br>DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoid Cancer<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |               |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |               |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |               |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |               | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |               | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/2/82 to 8/2/82, that (I) (we) lost saw the deceased alive on 8/2/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |               |   |   |  |  |  |
| 22b. SIGNATURE<br>H. I. Cook MD   |  | DEGREE  |               | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |   | 22c. DATE SIGNED<br>8/2/82   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. I. Cook MD  |  |   |               | 22e. ADDRESS<br>Baltimore City Hospital   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>8-5-82   |               | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.                 |  |  |
| 24. FUNERAL DIRECTOR<br>Prudzinski Funeral Home   |  |   |               | 25a. DATE RECEIVED BY BALTIMORE REGISTRAR<br>AUG - 3 1982   |   | 25b. SIGNATURE<br>Frances Jan Nathan   |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  | REG. NO. 8 2 2 0 8 3 0                       |  |
|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>EARL Franklin RUMSLEY</b>  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>8-7-82</b>                                      |  | 2b. HOUR<br>M<br><b>6:50P</b>   |  |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 / 26 / 27</b>   |  | 6. AGE (IN YEARS) IF UNDER 1 YR. LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>55</b> YRS.        |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>8-7-82</b>                                   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>18 E. 24th Street</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Factory worker</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hedwin</b>  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>18 E. 24th Street</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mac McKensy Rumsley</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kathleen Rumsley</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>220 12 6947</b>   |  | 17. INFORMANT ADDRESS<br><b>2445 Maryland Ave 21218</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4280</b> IMMEDIATE CAUSE <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>   |  |   |  | M.D. <b>Assistant</b>  |  |   |  | DATE SIGNED <b>8-8-82</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |  |   |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>8/13/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Veterans Cem</b>                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville A.A. Maryland</b>                |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Burgee Funeral Home</b>   |  |   |  | 3631 Falls Road 21211  |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>AUG 11 1982 Joan J. Connel</b> |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |                                   |  |  |
|--|--|--|--|---|--|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 2 2 0 8 3 1  |  |   |  |  |                                   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2b. DATE OF DEATH MONTH DAY YEAR  |  | 2c. HOUR   |                                   | 2d. MIN.   |  |
| WALTER R. RUTH   |  |  |  | August 17 1982  |  | 5 20 A   |                                   |  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS  |                                   | IF UNDER 24 HRS. HOURS MIN.  |  |
| Male   | White  | Aug. 30, 1904  |  | 77  |  |  |                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |                                   |  |  |
| Pennsylvania   | U.S.A.   |  |  | BALTIMORE CITY MD.  |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| BALTIMORE  | UNION MEMORIAL HOSPITAL  |  |  | Coal Tester   |  |  | Balto. G&E                        |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                   |  |  |
| Maryland   |  |  |  | Baltimore   |  | 13e. STREET ADDRESS  |                                   |  |  |
|  |  |  |  |   |  | 1463 Roland Heights Avenue   |                                   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |                                   |  |  |
| Nath S. Ruth   |  |  |  | Lizzie Reimold  |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS  |                                   |  |  |
| No   |  | 212 05 7398  |  | Sylvia Dumhart  |  | Same   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MASSIVE CEREBROVASCULAR ACCIDENT</u>  |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>IMMEDIATE</u><br><u>3 DAYS</u><br><u>7 DAYS</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NONE</u>   |  |  |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |                                   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 10, 1982</u> to <u>Aug. 17, 1982</u> , that (I) (we) last saw the deceased alive on <u>Aug. 16, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |                                   |  |  |
| <u>Ann D. Carter</u>   |  |  |  | MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 8-17-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |                                   |  |  |
| ANN D. CARTER  |  |  |  | UNION MEMORIAL HOSPITAL   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |                                   |  |  |
| Burial   |  | 8/20/82  |  | Poplar Grove Cemetery   |  | Warren, Balto. Co., Md.  |                                   |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |  |
| Burgee Funeral Home  |  |  |  | AUG 18 1982   |  | <u>John J. Carter</u>  |                                   |  |  |
| 3631 Falls Rd. 21211   |  |  |  |   |  |  |                                   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 2 0 8 3 2   |  |  |  |
|---|--|--|--|---|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ELEANOR RYAN   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 25 82   |  | 2b. HOUR<br>6 AM   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 18 11  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>✓  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>✓  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Donald  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Duvall  |  | 13e. STREET ADDRESS<br>2327 N. CHARLES STREET   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>154-05-5391  |  | 17. INFORMANT ADDRESS<br>MEDICAL RECORD   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u><br>4275 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                          |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Diabetes Mellitus, Dementia, Anemia</u>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>8/19</u> , 19 <u>82</u> , to <u>8/25</u> , 19 <u>82</u> , that (I) <del>lost</del> saw the deceased alive on <u>8/25</u> , 19 <u>82</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>may</del> did <del>not</del> view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>David M. Riffly</u>  |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>8/25/82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>David M. Riffly</u>   |  | 22e. ADDRESS<br><u>Union Memorial Hosp Baltimore Md 210</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal  |  | 23b. DATE<br>8/27/82   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board   |  |  |  | ADDRESS<br>Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 31 1982   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Joan J. Carver</u>   |  |  |  |

200 254

FORM NO. 64



200 254

200 254

200 254



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2. DATE OF DEATH   |  |  |  | 3. REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 20. DATE OF DEATH  |  |
| SACCO   |  | F  |  | Sacco  |  | Aug 17 82   |  | 26. HOUR 12:15 P   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  |
| Male  |  | Caucasian  |  | 9 20 17  |  | 64  |  | IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. IF UNDER 1 YEAR  |  |
| MD.   |  | USA  |  |  |  | Balt City   |  | MONTHS DAYS HOURS MIN.   |  |
| 11. CITY OR TOWN OF DEATH   |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  |  |  | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  | 14. KIND OF BUSINESS OR INDUSTRY                               |  |
| Baltimore   |  | University Hospital  |  |  |  | Teacher   |  |  |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 16. CITY OR TOWN   |  | 17. INSIDE CITY LIMITS?  |  | 18. STREET ADDRESS  |  | 19. MD.  |  |
| Md.   |  | Queen Annes  |  | Stevensville   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | PO Box 374   |  |
| 4. FATHER'S NAME  |  | 5. MOTHER'S MAIDEN NAME  |  | 6. ADDRESS   |  | 7. P.O. Box 374   |  | MD   |  |
| Sacco   |  | Joseph   |  | Carmela  |  | Bavaro  |  |  |  |
| 10a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 10b. SOCIAL SECURITY NO.   |  | 11. INFORMANT  |  | 12. ADDRESS   |  | 13. P.O. Box 374   |  |
| YES   |  | 219-07-3199  |  | Patient BEATRICE P. SACCO  |  | STEVENSVILLE  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  |
| 1629 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest   |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF liver metastases   |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF lung cancer  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)  |  |  |  |  |  |   |  |  |  |
| Peritonitis   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  | Brain Mets   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. PLACE OF INJURY  |  | 21e. LOCATION  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  | AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |  | CITY OR TOWN COUNTY STATE                                      |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  | 21g. CITY OR TOWN   |  | 21h. COUNTY  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/4/82 19 to 8/17/82 19, that (I) (we) last saw the deceased alive on 8/17/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | 22c. DEGREE  |  |  |  | 22d. DATE SIGNED  |  | 22e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| Jay R Schachner MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 8/17/82   |  |  |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22g. ADDRESS   |  |  |  | 22h. CITY OR TOWN   |  | 22i. COUNTY  |  |
| Schachner, Jay R  |  | UMN Dept Medicine  |  |  |  | EASTON  |  | TALBOT CO. MD.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. COUNTY  |  |
| Intombment  |  | Aug. 19, 1982  |  | Woodlawn Cemetery  |  | EASTON  |  | TALBOT CO. MD.   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  | 25c. CITY OR TOWN  |  |
| Helfenbein-Hubbard Funeral Home P.A. Chester Md.  |  | AUG 23 1982  |  |  |  | John J. Connelley   |  | BALTIMORE  |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 3 4

REG. NO.

|  |                  |  |  |   |  |
|--|------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Jean Veronica Sacilotto  |                  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 29 82 |   | 2b. HOUR<br>M  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 14 1913  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City   |                  | 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospitals                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |                  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STREET ADDRESS<br>2407 West Branch Road  |  |
| 13b. CITY OR TOWN<br>Dundalk   |                  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13d. STREET ADDRESS<br>2407 West Branch Road  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Rosario Cicero   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>[Not Known]   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |
| 16b. SOCIAL SECURITY NO.<br>219-30-5702  |                  | 17. INFORMANT<br>Harry B. Litchison  |  | ADDRESS<br>7401 Belclare Road<br>Balto. MD 21222  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) <u>metastatic carcinoma to brain</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 mos.</u>                            |                  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>6 mos.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |                  |  |  |   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/19/82</u> to <u>current</u> , that (I) (we) last saw the deceased alive on <u>8/30/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I) did not view the body after death. |                  |  |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |                  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  | 22c. DATE SIGNED<br>8/30/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SUBSANT J. CAMERON MD   |                  | 22e. ADDRESS<br>1012 North Pt Rd Balto, Md.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>9/1/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |                  | 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc. ADDRESS<br>7922 Wise Avenue, Dundalk, MD 21222  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>AUG 31 1982   |                  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |



RECEIVED  
JAN 10 1964  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]  
BY: [Illegible]  
TO: [Illegible]  
FROM: [Illegible]  
[The remainder of the memorandum body is illegible due to extreme fading.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  |  |  |
|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>JOHN   |  | MIDDLE<br>E  |  | LAST<br>SAGNER SR   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 29 82  |  | 2b. HOUR PM<br>5.30 <sup>M</sup>             |  |
| 3. SEX<br>Male   |  | 4. RACE<br>cauc   |  | 5. DATE OF BIRTH<br>9/4/22   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59   |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUN)<br>Pa.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>N. Charles General Hosp. |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE WORK FOR MOST OF WORKING LIFE)<br>Burner                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shipbuilding   |  |  |  |
| 11a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md. Elkridge   |  | 11b. COUNTY<br>How  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13c. STREET ADDRESS<br>6636 Washington Blvd   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Maurice - Sagner   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice - Short   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  |  | 17. INFORMANT<br>ADDRESS<br>186-16-3883 Melva Sagner 6636 Washington Blvd.   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4960 IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>C.O.-P.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br><u>Lungs only</u><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>8-20</u> , 19 <u>82</u> , to <u>8-29</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8-29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.          |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>R. G. A. Boland</u>   |  |   |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>8-29-82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. G. A. BOLAND   |  |   |  | 22e. ADDRESS<br>NORTH CHARLES HOSPITAL   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>9/3/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Carroll County Md.  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Schumnek Funeral Home Inc.<br>3331 Brehms Lane Balto., Md. 21213   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 31 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>   |  |  |  |

BP



SANDERLIN ROBERT

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that 09-26-82 09 be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical examiner's report must be attached.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 2 2 0 8 3 6  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROBERT SANDERLIN</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>August 9, 1982</b>  |  | 2b. HOUR<br><b>4:40A</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 - 26 - 09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>72</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Windsor, N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>1731 N. Washington Street</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>DAVID T. SANDERLIN</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>NANCY JANE BAZMORE</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>NO</b>  |  |   |  |
|  |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-2159</b>  |  | 17. INFORMANT<br><b>Cecil SANDERLIN 204 Maple Court</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br><b>1550</b><br>IMMEDIATE CAUSE (a) <b>EXAGGERATION - HYPOTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>RUPTURED HEPATOMA &amp; INTRAPERITONEAL HEMORRHAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HEMORRHAGE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 HR.</b> |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>8/9/82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>HYPOTENSION &amp; INTRAPERITONEAL HEMORRHAGE</b>                                     |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-9</b> , 19 <b>82</b> , to <b>8-9</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8-9</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>S. STUART</b>   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>8-9-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. STUART</b>  |  | 22e. ADDRESS<br><b>601 N. BROADWAY TRACT. (THH)</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (RECEIVED)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8-14-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hogarth Cherry Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Blacksie North Carolina</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>William J. Spicer</b>  |  | 24b. ADDRESS<br><b>1639 N. Broadway</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 12 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>   |  |

100



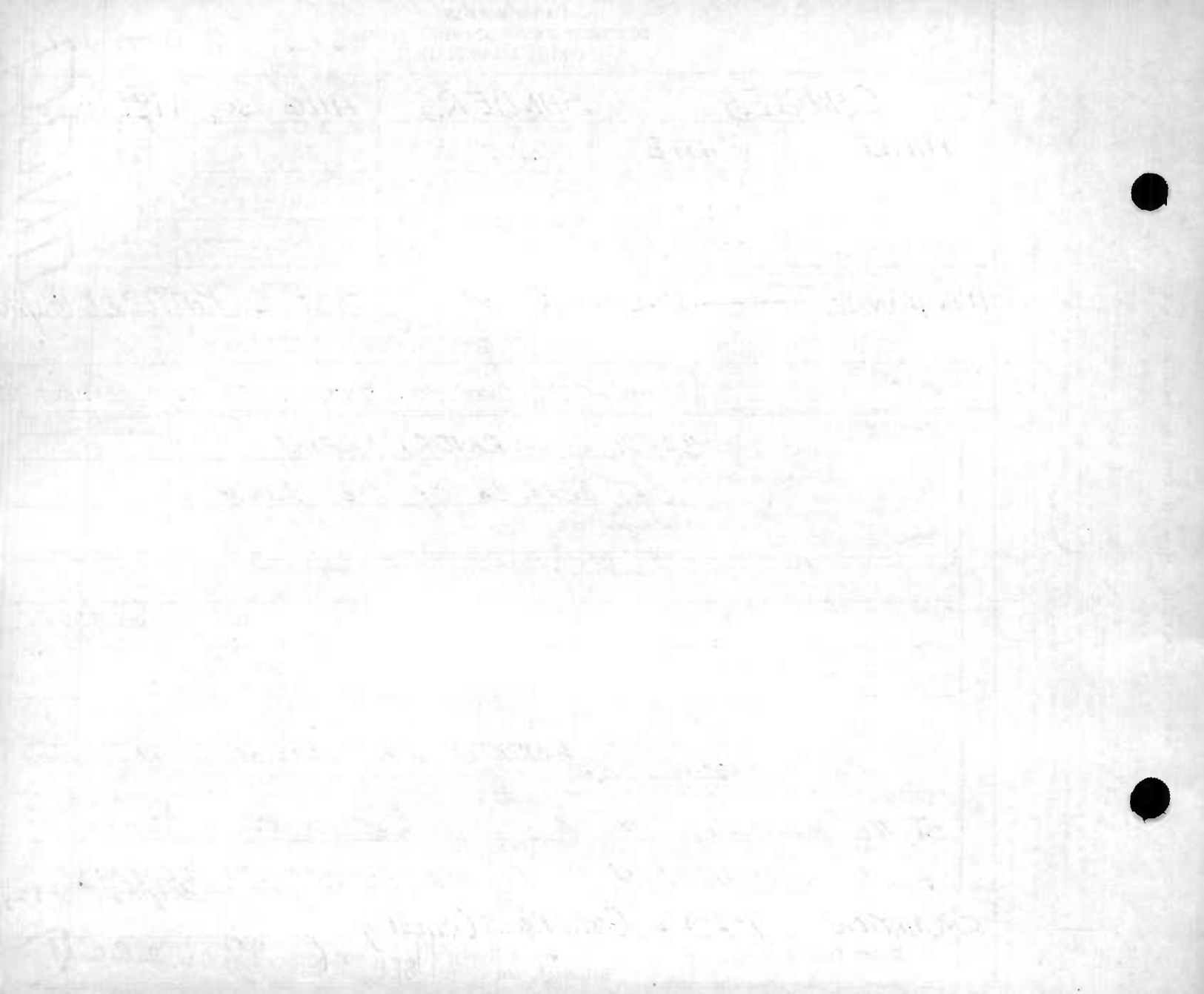
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| FOR<br>STATE<br>REGISTRAR   |  | 8 2 2 0 8 3 7  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br><b>CHARLES SANDERS</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>AUG 30, 1982</b>   |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Dec. 7, 1927</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Florida</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b>   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore,</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>330 S. Patterson Park Ave.</b> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.   |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>BALTIMORE</b>   |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Walter Sanders</b>   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Roslea Williams</b>  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Repairman</b>  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b SOCIAL SECURITY NO.<br><b>WW 2</b>   |  | 17 INFORMANT ADDRESS<br><b>Charlotte Sprouse 330 S. Patterson Pk</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>OLT CELL CA OF THE LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 19 82</b> to <b>AUG. 30 82</b> , that (I) (we) lost saw the deceased alive on <b>AUG. 30 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>J. M. Jumanoy, M.D.</b>  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>8/30/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. M. JUMANOY, M.D.</b>   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL; 100 N. BROADWAY</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>9-2-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CREMATORY</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Dippel Funeral Homes, Inc.</b>  |  | ADDRESS<br><b>7110 Belair Road Baltimore, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 2 1982</b>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>   |  |



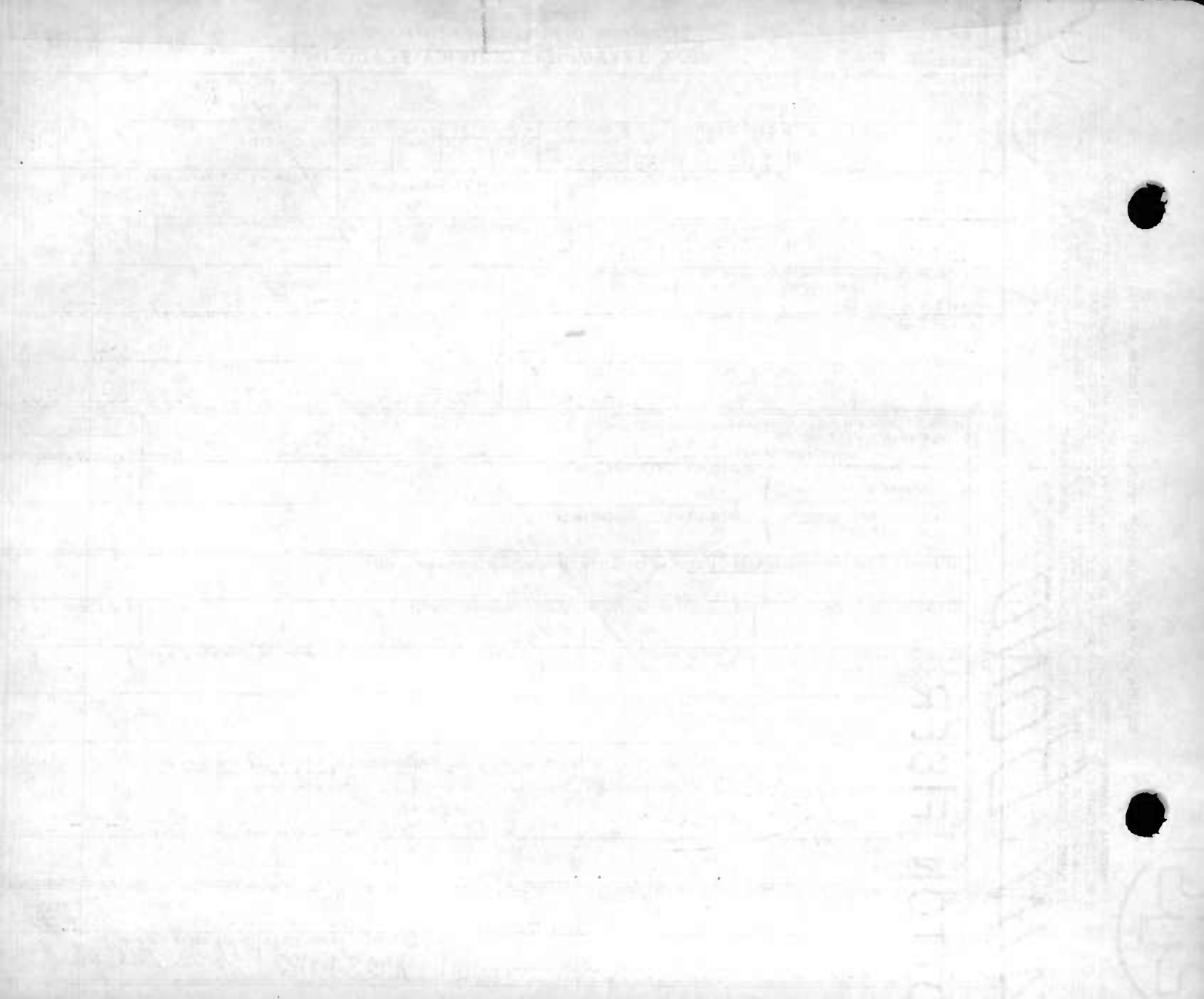
3 6 1- FOR STATE REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                  |   |  |   |   |   |                                   |   |  |
|---|------------------|---|--|---|---|---|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Odell Sanders Jr.  |                  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>8 29 1982            |   |   | 2b. HOUR<br>M   |                                   |   |  |
| 3. SEX<br>Male  | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 9 39   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>42 YRS.                | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 7c. DATE PRONOUNCED DEAD<br>8 29 1982   | 2d. HOUR<br>P.M.  |                                   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1516 Rutland Avenue |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br>Maryland  |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET ADDRESS<br>1729 E. Federal Street                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Odell Sanders, Sr.  |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susie Brown |   |   |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-34-5625  |  | 17. INFORMANT<br>ADDRESS<br>Susie B. Massey 1729 E. Federal St.   |   |   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                  |   |  |   |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                  |   |  |   |   |   |                                   |   |  |
| 19a. DATE OF OPERATION  |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |   |   |   |                                   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |                                   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural Causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |   |   |                                   |   |  |
| ACTUAL SIGNATURE<br><i>[Signature]</i>  |                  |   | TITLE (SPECIFY)<br>M.D. Assistant                            |   |   | MEDICAL EXAMINER  |                                   | DATE SIGNED 8-30-82   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |                  |   | ADDRESS<br>111 Penn Street                                   |   |   |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |                  | 23b. DATE<br>9/3/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North avenue   |                  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 31 1982  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |                                   |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |                  |                  |   |  |   |  |   |      |  |  |   |  |   |                       |  |  |
|--|--|------------------|------------------|---|--|---|--|---|------|--|--|---|--|---|-----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Presley |   |  | MIDDLE<br>Sapp                                |  |   | LAST |  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>8 21 19 82                             |  |   | 2b. HOUR<br>M<br>4:41 |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT. 18, 1927  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>54 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |      | IF UNDER 24 HRS.                                   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>8 21 19 82                            |  |   | 2d. HOUR<br>M<br>4:41 |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |      |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                          |  |   |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>306 W. Franklin St -alley |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>INSPECTOR  |      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BENDIX CO.                                     |  |   |                       |  |  |
| 13a. STATE<br>MARYLAND   |  |                  |                  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>RANDALLSTOWN             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |      | 13e. STREET ADDRESS<br>3503 FOX CLIFF CT., APT 202 |  |   |  | 13f. CITY OR TOWN<br>BALTIMORE  |                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ELLIS SAPP   |  |                  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JESSIE WEINER  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES  |      |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>ARMY-KOREA 216-20-9153HA |  | 17. INFORMANT<br>MRS. DORIS SAPP<br>3503 FOX CLIFF CT., APT. 202 #21133 |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9571 IMMEDIATE CAUSE (a) Multiple injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |                  |   |  |   |  |   |      |  |  |   |  |   |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |                  |   |  |   |  |   |      |  |  |   |  |   |                       |  |  |
| 19a. DATE OF OPERATION   |  |                  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |      |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |                       |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>4:15 P.M. 8/21 19 82   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Jumped from from window  |      |  |  |   |  |   |                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>hotel  |  |   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CongressHotel, 306W Franklin St, Balto., MD   |      |  |  |   |  |   |                       |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                  |                  |   |  |   |  |   |      |  |  |   |  |   |                       |  |  |
| ACTUAL SIGNATURE<br>Hormez R. Guard  |  |                  |                  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER  |      |  |  | DATE SIGNED<br>8/22/82  |  |   |                       |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.  |  |                  |                  | ADDRESS<br>111 Penn Street, Balto., MD 21201  |  |   |  |   |      |  |  |   |  |   |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |                  |                  | 23b. DATE<br>AUG. 23, 1982  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>TIFERETH ISRAEL   |      |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD                    |  |   |                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.   |  |                  |                  | ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 24 1982  |      |  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Gault   |  |   |                       |  |  |

BP

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 17 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 2 0 8 4 0   |  |  |  |
|---|--|--|--|---|--|--|--|
| FOR<br>1. STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIOLET MARIE C. SCHEFFEL</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8/3/82</b><br>2b. HOUR<br><b>749</b> <sup>PM</sup>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 07 12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SEAMSTRESS</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE CLARK</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORA KUMMER</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-05-3903</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>FREDERICK H. SCHEFFEL 4618 LEEDS AVENUE 21229</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4860 IMMEDIATE CAUSE (a) Cardio pulmonary Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Pneumonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Arteriosclerotic Cardiovascular Disease</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <b>August 3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Joseph H. Miller MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>8/3/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Joseph Miller</b>   |  |  |  | 22e. ADDRESS<br><b>900 S. Caton Ave (21229)</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>08-06-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELK RIDGE HOWARD MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG - 6 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gmish</b>   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
| REG. NO. 8 2 2 0 8 4 1   |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JENNIE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-6-82</b> |   |  | 2b. HOUR<br><b>538P</b>   |  |  |  |
| 1. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 11 93</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78 99</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3328 RIPPLE Rd #21207</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SIMON LEWIS TAYLOR</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LENA ROSENTHAL</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-52-7149</b>  |  | 17. INFORMANT <b>Mrs. Sonya SSBIE</b><br><b>3328 RIPPLE Rd. #21207</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>A. S. C. V. D.</b> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs</b><br><b>24 hrs</b><br><b>15 Y</b>                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>Eduardo Anhalt</b><br>DEGREE   |  |  |  |   |  | 22c. DATE SIGNED<br><b>8-6-82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDUARDO ANHALT</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL BALT, MD.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8-8-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BNAI ISRAEL CONG.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>                               |  |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>   |  |  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>AUG 10 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |

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SAVING THE WORLD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

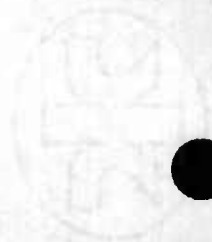
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 2 0 8 4 2  |  |   |  |
|---|--|---|--|--|--|---|--|
| FOR<br>STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH  |  |   |  |
| Evelyn T. Schlutter   |  |   |  | August 27, 1982  |  |   |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |
| Female  |  | White   |  | 3 / 1 / 17   |  | 65 YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |
| Maryland  |  | U.S.A.  |  |  |  | Baltimore City MD.  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore   |  | Union Memorial Hospital   |  | Housewife  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |  |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>(TYPE OR PRINT)   |  | 15 MOTHER'S MAIDEN NAME<br>(TYPE OR PRINT)  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |
| Joseph  |  | Dorothea Jackson  |  | No   |  | 212-03-2689   |  |
| 17 INFORMANT  |  | ADDRESS   |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute large cordial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>M.A.S.C.U.D.</u><br>(b) <u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>4100</u><br>(c) <u>4100</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |
| Robert H. Schlutter   |  | 3004 Iona Terrace   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 1/2 hours</u><br><u>years</u>   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDER (TYPE) <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/27/82</u> 19 <u>82</u> to <u>present</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/27/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Gerald Maggid M.D.</u> DEGREE  |  | 22c. DATE SIGNED<br><u>8/2/82</u>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gerald Maggid, M.D.        |  |
| 22e. ADDRESS<br>8100 Harford Road Baltimore, Maryland   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |
|   |  | Burial  |  | Aug. 30, 1982  |  | Woodlawn  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  | 25c. DATE SIGNED  |  |
|   |  | AUG 30 1982   |  | <u>John J. Carick</u>  |  |   |  |

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For the purpose of the above  
contract

~~RECEIVED~~  
10/1/19



For the purpose of the above  
contract

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 0 8 4 3  
CERTIFICATE OF DEATH

|  |  |   |                             |
|--|--|---|-----------------------------|
| FOR<br>1. STATE<br>REGISTRAR   |  | REG. NO.  |                             |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Arnold F. Schmick</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR 8 19 82 2b. HOUR 526 P.M.  |                             |
| 3. SEX <b>Male</b>   | 4. RACE <b>Cauc</b>                        | 5. DATE OF BIRTH MONTH DAY YEAR 4 7 23  |                             |
| 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.  | IF UNDER 1 YEAR MONTHS DAYS                |   | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.-U.S.A.</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>City Balto.</b> MD.  |  | 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |                             |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SBCH</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disability, Machinist, W.R. Grace</b>  |                             |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STATE <b>MD.</b> 13b. COUNTY   |                             |
| 13c. CITY OR TOWN <b>Balt.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                             |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Arnold F. Schmick Sr.</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Appolonia - Newman</b>  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO. <b>213-206902</b>  |                             |
| 17. INFORMANT <b>Wife</b>  |  | ADDRESS <b>3424 7th St.</b>   |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>4349<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Extensive right cerebral infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |                             |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |                             |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                             |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-19 1982, to 8-19 1982, that (I) (we) last saw the deceased alive on 8-19 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |   |                             |
| 22b. SIGNATURE <b>M. Nestor</b> DEGREE <b>M.D.</b>   |  | 22c. DATE SIGNED <b>8-19-82</b>   |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. Nestor</b>   |  | 22e. ADDRESS <b>3001 South Hanover, Balt, MD.</b>   |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>Aug. 23, 1982</b>  |                             |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A.A. Co. Maryland</b>   |                             |
| 24. FUNERAL DIRECTOR <b>McQuilly Funeral Home, 237 E. Patapsco Ave. Balto.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1982</b>  |                             |
| 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>   |  |   |                             |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 338-2200.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 2 0 8 4 4<br>REG. NO.  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR <b>MARTIN</b>   |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARTIN - N. SCHNAPER</b>  |  |  |  | 2b. DATE OF DEATH MONTH DAY YEAR 8-14-82 2b. HOUR 3:09 PM  |  |   |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 27, 1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>LIQUOR</b>   |  |
| 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>23 WARREN PARK DR. (21208)</b>       |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY SCHNAPER</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DORA ROSEMAN</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>213-12-4645</b>  |  | 17. INFORMANT ADDRESS <b>1st FLOOR MRS. ROSE SCHNAPER 23 WARREN PARK DR. (21208)</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>AWOTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>A.S.C.V.D.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>36 hrs</b><br><b>20 Yrs</b> |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Eduardo Anhalt</b> DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  | 22c. DATE SIGNED <b>8-14-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDUARDO ANHALT</b>  |  |  |  | 22e. ADDRESS <b>Sinai Hospital Balt, MD</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>AUGUST 14, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>TIFERETH ISRAEL CEM</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTIMORE MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>  |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215  |  |  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |   | 8 2 2 0 8 4 5                                |          |                              |  |                  |          |  |
|---|--|--|--|--|--|--|--|--|---|--|----------|------------------------------|--|------------------|----------|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.   |  |  |  |  |  |   |  |          |                              |  |                  |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST  |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR  |  | 2b. HOUR |                              |  |                  |          |  |
| IDA   |  |  | BARR   |  |  | SCHROEDER  |  |  | Aug 14 82   |  |          | 10.48 AM                     |  |                  |          |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |          | IF UNDER 1 YEAR              |  | IF UNDER 24 HRS. |          |  |
| FEMALE  |  |  | WHITE  |  |  | DEC. 25, 1882  |  |  | 99 YRS.   |  |          | MONTHS                       |  | DAYS             |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |          |                              |  |                  |          |  |
| RUSSIA  |  |  | USA  |  |  |  |  |  | BALTIMORE CITY  |  |          | MD.                          |  |                  |          |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |                              |  |                  |          |  |
| BALTIMORE CITY  |  |  | NORTH CHARLES GENERAL HOSPITAL   |  |  | HOUSEWIFE  |  |  | AT HOME   |  |          |                              |  |                  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |          | 13e. STREET ADDRESS          |  |                  |          |  |
| MARYLAND  |  |  |  |  |  | BALTIMORE  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          | 2500 W. BELVEDERE AVE. 21215 |  |                  | APT. 706 |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |   |  |          |                              |  |                  |          |  |
| JOSEPH  |  |  | BARR   |  |  | EMMA   |  |  | UNKNOWN   |  |          |                              |  |                  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  |   |  |          |                              |  |                  |          |  |
| NO  |  |  | 218-54-0932  |  |  | MR. EMORY SCHROEDER  |  |  | 5956 E. PRATT ST.   |  |          | BALTO., MD                   |  |                  | 21224    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |                              |  |                  |          |  |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA AND ARREST</u>  |  |  |  |  |  |  |  |  |   | 15 min.                                      |          |                              |  |                  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |   | 3+ years                                     |          |                              |  |                  |          |  |
| (b) <u>CORONARY ARTERY DISEASE AND HEART FAILURE</u>  |  |  |  |  |  |  |  |  |   |  |          |                              |  |                  |          |  |
| (c) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE SENILITY</u>  |  |  |  |  |  |  |  |  |   |  |          |                              |  |                  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |  |  |  |  |  |  |   |  |          |                              |  |                  |          |  |
| <u>GALL BLADDER DISEASE, DIABETES, CHRONIC RENAL FAILURE</u>  |  |  |  |  |  |  |  |  |   |  |          |                              |  |                  |          |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |          |                              |  |                  |          |  |
| 8/13/82   |  |  | GALL BLADDER DISEASE   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |          |                              |  |                  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |          |                              |  |                  |          |  |
| N/A   |  |  | HOUR A.M. MONTH DAY YEAR   |  |  | N/A  |  |  |   |  |          |                              |  |                  |          |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OR FARM, ETC.)  |  |  | 21f. LOCATION  |  |  | CITY OR TOWN  |  |          | COUNTY STATE                 |  |                  |          |  |
| N/A   |  |  | N/A  |  |  | N/A  |  |  | N/A   |  |          |                              |  |                  |          |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>8/13</u> , 19 <u>82</u> , to <u>8/14</u> , 19 <u>82</u> , that (we) last saw the deceased alive on <u>8/14/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |   |  |          |                              |  |                  |          |  |
| 22b. SIGNATURE  |  |  |  |  |  | DEGREE   |  |  | 22c. DATE SIGNED  |  |          |                              |  |                  |          |  |
| Charlotte L. L. L.  |  |  |  |  |  | MD   |  |  | 8/14/82   |  |          |                              |  |                  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  | 22e. ADDRESS   |  |  |   |  |          |                              |  |                  |          |  |
| WATCHAVAL VUTHIBANON  |  |  |  |  |  | NORTH CHARLES GENERAL HOSPITAL   |  |  |   |  |          |                              |  |                  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION   |  |          | COUNTY STATE                 |  |                  |          |  |
| BURIAL  |  |  | AUG. 16, 1982  |  |  | AITZ CHAIM   |  |  | BALTIMORE   |  |          | MARYLAND                     |  |                  |          |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |          |                              |  |                  |          |  |
| SOL LEVINSON & BROS., INC.  |  |  |  |  |  | AUG 17 1982  |  |  | John J. Carver  |  |          |                              |  |                  |          |  |
| 6010 REISTERSTOWN RD. BALTO., MD  |  |  |  |  |  | 21215  |  |  |   |  |          |                              |  |                  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 0 8 4 6   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>VIOLA Agnes SCHROEDER  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 27 82   |  | 2b. HOUR<br>130P M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 5, 1898   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret/ Seamstress   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry C. Evans  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine E.  |  | 13e. STREET ADDRESS<br>742 Mc Kewin Ave.  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-07-1954   |  | 17. INFORMANT ADDRESS<br>7845<br>Mrs. Elizabeth O. Smith Eastdale Rd. 21224   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cancer of pancreas</u><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>150 P.M. 8 27 1982  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>8/27</u> 19 <u>82</u> to <u>8/27</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/27</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Irving Gottfried  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>IRVING GOTTFRIED MD  |  | 22e. ADDRESS<br>Union Memorial Hospital<br>201 E. University Pkwy. Balto. 21218  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>8/31/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. 5305 Harford Rd.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 30 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel  |  |

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

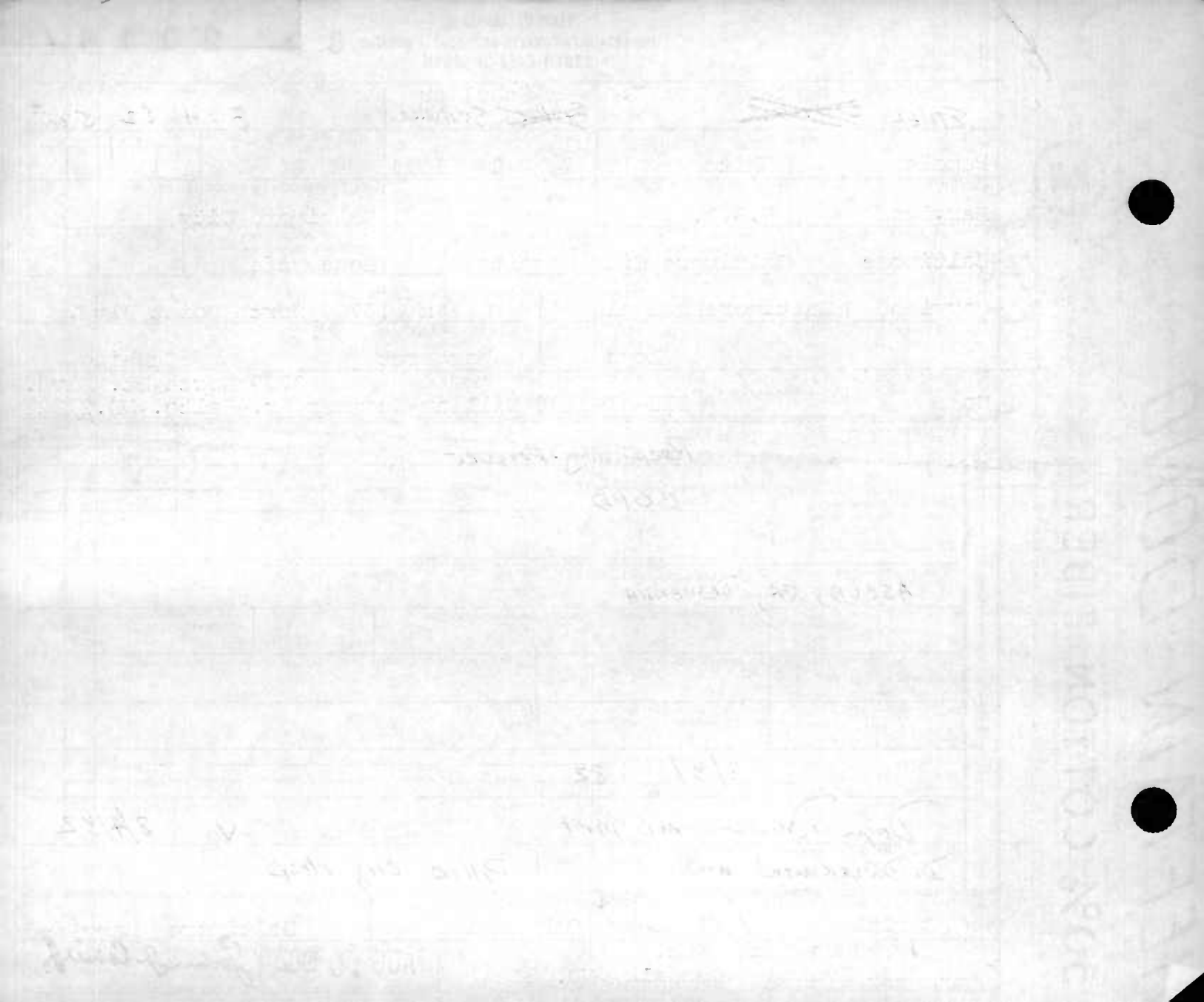
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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                                      |  |  |
|---|--|---|---|---|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Ethel</u> MIDDLE <u>I.</u> LAST <u>Schuller</u><br><del>ETHEL SCHULLER</del>  |  |   | 2a. DATE OF DEATH<br>MONTH <u>8</u> DAY <u>4</u> YEAR <u>82</u> |   | 2b. HOUR<br><u>5:00</u> <sup>A</sup> |  |  |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>White</u>   |   | 5. DATE OF BIRTH<br>MONTH <u>7</u> DAY <u>8</u> YEAR <u>1898</u>  |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>84</u> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Baltimore City Hospital</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Housewife</u>  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>Maryland</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Dundalk</u>  |  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      | 13e. STREET ADDRESS<br><u>3700 North Point Blvd.</u>   |  |
| 14. FATHER'S NAME<br>FIRST <u>Key</u> MIDDLE <u>Key</u> LAST <u>Key</u>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Margaret</u> MIDDLE <u>Cushing</u> LAST <u>Cushing</u>   |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>No</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>215-01-3198</u>  |   | 17. INFORMANT<br><u>William Kuemmer, Sr. - Balto., MD. 21222</u>  |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><u>4960</u> IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |   |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>ASCVD, RA, DEMENTIA</u>   |  |   |   |   |                                      |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>8/3/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |   |   |                                      |  |  |
| 22b. SIGNATURE<br><u>Dora Schuller MD, MPT</u>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                      | 22c. DATE SIGNED<br><u>8/4/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>D. DRUCKMAN MD</u>  |  |   |   | 22e. ADDRESS<br><u>13700 City Hosp</u>  |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>8/7/1982</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Lawn</u>   |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Maryland</u>  |  |
| 24. FUNERAL DIRECTOR <u>Duda-Ruck, Inc.</u><br>NAME ADDRESS<br><u>7922 Wise Avenue Dundalk, MD. 21222</u>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>AUG 10 1982</u>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>   |  |





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 4 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Emma L Schultz</i>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>8-3-82</i>                                     |   | 2b. HOUR<br>M                                |
| 3. SEX<br><i>F</i>  | 4. RACE<br><i>W</i>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>8 23 14</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><i>67</i> YRS.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>BALTO</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTO. CITY</i> MD.                                  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Home maker</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Balto.</i>  | 13c. CITY OR TOWN<br><i>Balto.</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Rudolph Stahn</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Elizabeth Miller</i>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>215-03-20290</i>   |   | 17. INFORMANT ADDRESS<br><i>Mrs. Elizabeth R. Krug 5806 N. Hazelwood Ave Balto. Md.-21206</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br><i>5119</i> IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>MASSIVE ASCITES 2° TO CANCER</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>LARGE LEFT PLEURAL EFFUSION 2° TO CIA</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |   |   |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |
| 22b. SIGNATURE<br><i>David L. Yi, MD</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><i>8/3/82</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DAY, MD</i>   |  | 22e. ADDRESS  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>8-6-82</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gardens of Faith Cem.</i>                              |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>  |  | 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>John C. Miller Inc-6415 Belair Rd.-21206</i>  |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Canine</i>   |   |   |  |

MEDICAL CERTIFICATION

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*Submitted: February 19, 1987*

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 0 3 4 9<br>REG. NO.   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ROBERT A. SCHWARTZ  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>08 07 82   |  | 2b. HOUR<br>2am M   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 21 03   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF DECEASED IN A CARE FACILITY, GIVE FULL ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Construction  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Schwartz  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Mills   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-01-4255  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Katharine L. Schwartz Balto., Md.<br>1109 Ramblewood Road  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Esophageal Ca.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>6/16/82  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>adenocarcinoma Esophagus  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/2, 19 82, to 8/7, 19 82, that (I) (we) lost<br>saw the deceased alive on 8/7, 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Randall A. Riegler MD  |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  | 22c. DATE SIGNED<br>8/7/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RANDALL A. RIEGLER MD   |  |   |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  | 23b. DATE<br>8/7/82   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  |   |  | ADDRESS<br>Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 10 1982  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be signed by the medical examiner.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | 8 2 2 0 8 5 1  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>PIER Francesco Scipioni</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 15 1982</b>                      |   | 2b. HOUR<br><b>2:25 A.M.</b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 09 1916</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b><br>YRS. MONTHS DAYS HOURS MIN.                     |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE - CITY.</b> MD.                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALES</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bakery</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>M.D.</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6001 THE ALAMEDA</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Oscar Scipioni</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hollyholgoude Sapede</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-28-2533</b>   |  | 17. INFORMANT ADDRESS<br><b>Virginia T. Scipioni 6001 The Alameda 21239</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION.</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIO-RESP. FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MYOCARDIAL INFARCTION?</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ASCITES, C.A.O., A.S.H.O.</b>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. — 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>(7:12 PM) — 2:25 AM</b>   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-14-82 (7:12 PM)</b> 19 <b>82</b> , to <b>8-15-82</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8-14-82 (7:12 PM)</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Shillom MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>8-15-82</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SURINDER P. DHILLON</b>  |  |   |  | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSPITAL BALTO-MD</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8-18-1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore — Maryland</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Rd 21212</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE<br><b>AUG 20 1982 John J. Gaher</b>  |  |   |  |  |  |



item 7a #G570 8/20/82 ph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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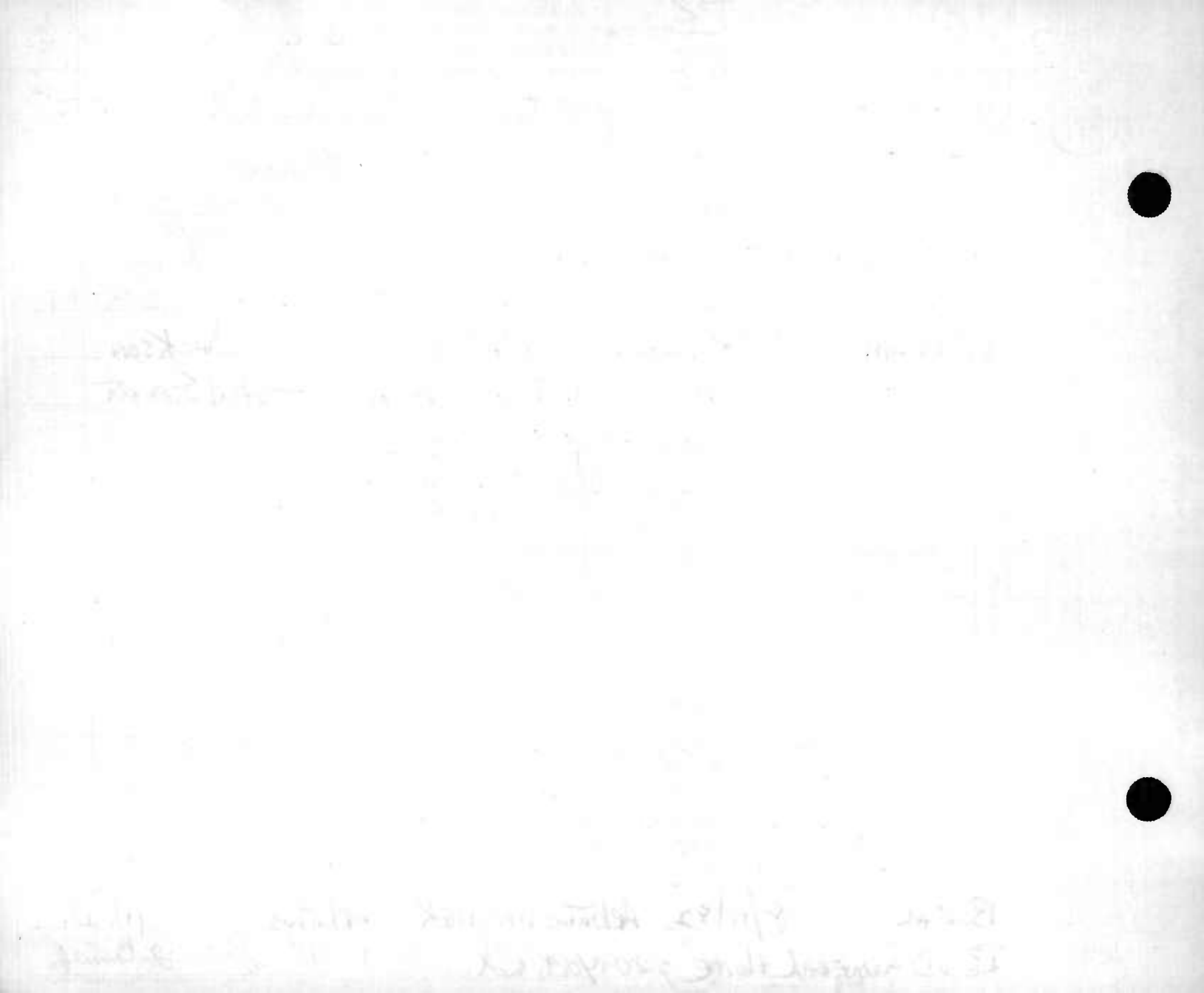
REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LELIA</b>  |  | FIRST<br><b>SCOTT</b>  |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8/8/82</b>  |  | 2b. HOUR<br><b>3:55<sup>PM</sup></b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 1 98</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MT. SINAI NRSG. HOME</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALT.</b>  |  | 13c. CITY OR TOWN<br><b>BALT.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1101 ST. PAUL STREET</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Robinson</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie Jackson</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>171-10-5130</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Ellen Green 1101 St Paul Street</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac &amp; Respiratory Arrest</b><br><b>4049</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis, Cardiovascular Renal Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <b>Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Failure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>5 years</b> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>None</b>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 10</b> , 19 <b>77</b> , to <b>Aug 8</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Aug 8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Manuel Levin</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>8/10/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANUEL LEVIN</b>   |  | M.D.   |  | 22e. ADDRESS<br><b>6101 PK Hts Ave, BALTO MD 21215</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/11/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus M. D.</b>                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Redd Funeral Home</b>   |  | ADDRESS<br><b>5209 York Rd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours following death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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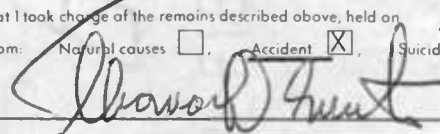
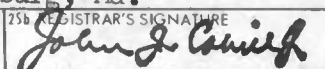
REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary SCOTT</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 3 83</b>                   |   |  | 2b. HOUR<br><b>3<sup>30</sup> AM</b>   |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br><b>9/5/1881</b>   |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>100</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>City, Bmtd.</b> MD.                          |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bmtd.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Eastern Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housew. Co.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13a. STATE<br><b>MD</b>  |  |  |   |  |
| 13b. COUNTY<br><b>MD</b>  |  | 13c. CITY OR TOWN<br><b>Bmtd.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>3801 Borden Rd.</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>219-055324C</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>C. Dorsey 3801 Borden Rd.</b>            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>5860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension/Hypocalcemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal Failure/Sepsis</b>                                |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  | 19d. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/3</b> 19 <b>82</b> to <b>8/3</b> 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>8/3</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>John A. Connors</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/3/82</b>                                      |   |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN CONNORS</b>  |  |  |  |   | 23b. ADDRESS   |  |  |   |  |
| 23c. BURIAL, CREMATION, REMOVAL<br>(CITY)   |  |  | 23d. DATE<br><b>8/6/82</b>   |   | 23e. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Co.</b>   |  | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Al. H. Conroy Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |  |  |   | 25. DATE REC'D. BY REGISTRAR<br>REGISTRAR'S SIGNATURE<br><b>1712 W. North</b><br><b>AUG 4 1982</b>   |  |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |  |                     |   |  |   |  | REG. NO. |
|--|-------------------------|--|---|--|---------------------|---|--|---|--|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James F. Seal 3rd.</b>  |                         |  |   |  |                     | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 15 1982</b>            |  | 2b. HOUR <b>M</b>   |  |          |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>July 18, 1966</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>16</b> | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>8 15 1982</b>   |  | 2d. HOUR <b>3:47 P.M.</b>   |  |          |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>  |                         | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>  |  |   |  |          |
| 11. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital - STU</b> |   |  |                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |          |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. CITY OR TOWN<br><b>Balto.</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                     | 13e. STREET ADDRESS<br><b>11958 Park Heights Ave.</b>   |  |   |  |          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James F. Seal Jr.</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy R. Ditzel</b>  |                     |   |  |   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>213-98-5675</b>   |   | 17. INFORMANT ADDRESS<br><b>Mr. James F. Seal Jr. Owings Mills, Md.</b>  |                     |   |  |   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>8120 IMMEDIATE CAUSE (a) Traumatic Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |   |  |                     |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |   |  |                     |   |  |   |  |          |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |                     |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR <del>XX</del> MONTH DAY YEAR<br><b>2:15 P.M. 8 15 1982</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>driver in motorcycle/motorcycle collision</b>                            |                     |   |  |   |  |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Field (rear)</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN STATE<br><b>12015 Park Heights Ave., Wood-lawn, Balto. Co., Md.</b>   |                     |   |  |   |  |          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |  |                     |   |  |   |  |          |
| ACTUAL SIGNATURE<br>  |                         | TITLE (SPECIFY)<br><b>M.D. Deputy Chief</b>  |   | MEDICAL EXAMINER   |                     | DATE SIGNED <b>8-16-82</b>  |  |   |  |          |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |                         | ADDRESS<br><b>111 Penn Street</b>  |   |  |                     |   |  |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>Aug. 18, 82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Memorial</b>  |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Finksburg, Md.</b>   |  |   |  |          |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Eline Funeral Home Reisterstown, Md. 21136</b>  |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 17 1982</b>  |                     | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |          |





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

2 0 8 5 5

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |  |   |  |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BLANCHE Seidenberg</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-23-82</b>                                    |   |  | 2b. HOUR<br><b>12:04 PM</b>  |   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 7 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> 90 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE HEBREW HOME</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5810 GIST AVE. #21215</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LEOPOLD ROSENHEIM</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH FRIED</b>                      |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-48-1076</b>            |   | 17. INFORMANT<br><b>MR. HENRY P. SOHN</b>                      |  |   |  | 6303 PARK HTS. AVE. BALTO., MD 21215                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1579 CA PANGLOSS</b><br>IMMEDIATE CAUSE (a) <b>CA PANGLOSS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8-7-82</b>  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                               |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-1</b> 19 <b>81</b> to <b>8-23</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8-23</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.        |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>B. ZAWCIN</b>   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8-23-82</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. ZAWCIN</b>  |  |   | 22e. ADDRESS<br><b>Levinson &amp; Bros., Inc. 6010 Reisterstown Rd. Balto., MD 21215</b> |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>AUG. 24, 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTIMORE MARYLAND</b>                               |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 26 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 0 8 5 6   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Martha Seifert</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8/27/82</b>   |  | 2b. HOUR<br><b>8:15 A.M.</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>cauc</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 22 99</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPERATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5028 East Oliver Street</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Factory Worker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Crown Cork &amp; Seal</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Greer Kendall</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Betty Marshall</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>235-05-9312</b>   |  | 17. INFORMANT ADDRESS<br><b>David Evans 24 Baltistan Ct.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>1520</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Duodenal carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>about</b> 19 <b>78</b> , to <b>8/5/82</b> , that (I) (we) last saw the deceased alive on <b>8/5</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert Fisher</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>8/15/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT FISHER</b>  |  | 22e. ADDRESS<br><b>6918 Ridge Rd. Balto, Md. 21237</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>8/27/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ellison Cemetary</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Peterstown, W. Va.</b>  |  |
| 24. FUNERAL HOME<br><b>Schmuneck Funeral Home Inc. 3331 Brehms Lane Balto., Md. 21213</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 31 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |   |  |  |                     | REG. NO. 20857  |  |
|--|--|-------------------------|--|---|--|---|--|--|---------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Andrew Sekloski</b>   |  |                         |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MATED <input checked="" type="checkbox"/> 8 9 1982  |                     | 2b. HOUR<br>M   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 26 94</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>88 YRS.</b>                          |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>8 23 1982</b>   |                     | 2d. HOUR<br>M<br><b>2:10</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>U.S.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>259 S. Ann St.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                     | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Md.</b>   |  |                         |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                     | 13e. STREET ADDRESS<br><b>259 S. Ann St.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                 |  |  |                     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |  |                         |  | (IF YES, GIVE WAR OR DATES)<br><b>WWI</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-12-3508</b>                                |  | 17. INFORMANT<br>ADDRESS <b>259 S. Ann St. Balto., Md.</b>   |                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |  |   |  |   |  |  |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |   |  |  |                     |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |                     | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |                     |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |                     |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |  |                     |   |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |                         |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |  | DATE SIGNED 8-24-82 |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                         |  |   |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>                                |  |  |                     |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  |                         |  | 23b. DATE<br><b>9/2/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>   |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Conish</b>  |                     |   |  |

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250

CONFIDENTIAL



MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon-copy pages. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | SH# 00-34-24<br>BALTIMORE<br>BD 01-13-1994   |  | 20858<br>ADM 10/25/82   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>LENA</b>  |  |   |  | 2a. DATE OF DEATH MONTH <b>08</b> DAY <b>08</b> YEAR <b>82</b>   |  | 2b. HOUR <b>5:45</b> M  |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH <b>01</b> DAY <b>13</b> YEAR <b>1894</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINDALE HEBREW HOME</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  |  |   |  |  |  |   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS <b>2500 W. BELVEDERE AVE. #21215</b>  |  |   |  |  |  |   |  |
| 14. FATHER'S NAME FIRST <b>SOLOMON</b> MIDDLE LAST <b>BERMAN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE LAST <b>WEINSTEIN</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>218-18-9458</b>   |  | 17. INFORMANT <b>MRS. HARRY LIPSITZ</b> ADDRESS <b>13 OAK HOLLOW CT. BALTO., MD 21208</b>  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br><b>4599</b> IMMEDIATE CAUSE (a) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>GANGRENE, LEFT FOOT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ISCHEMIC VASCULAR DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>7 mks</b><br><b>YEARS</b> |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-29</b> , 19 <b>80</b> , to <b>8-5</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8-8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |  | 22c. DATE SIGNED <b>8/8/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. ZAW-WIN M.D.</b>  |  |   |  | 22e. ADDRESS <b>BEVINOME GERIATRIC HOSP + CTR BALTO 21215</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>AUG. 9, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BETH EL MEMORIAL PARK</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>RANDALLSTOWN BALTO. MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1982</b>   |  |   |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |

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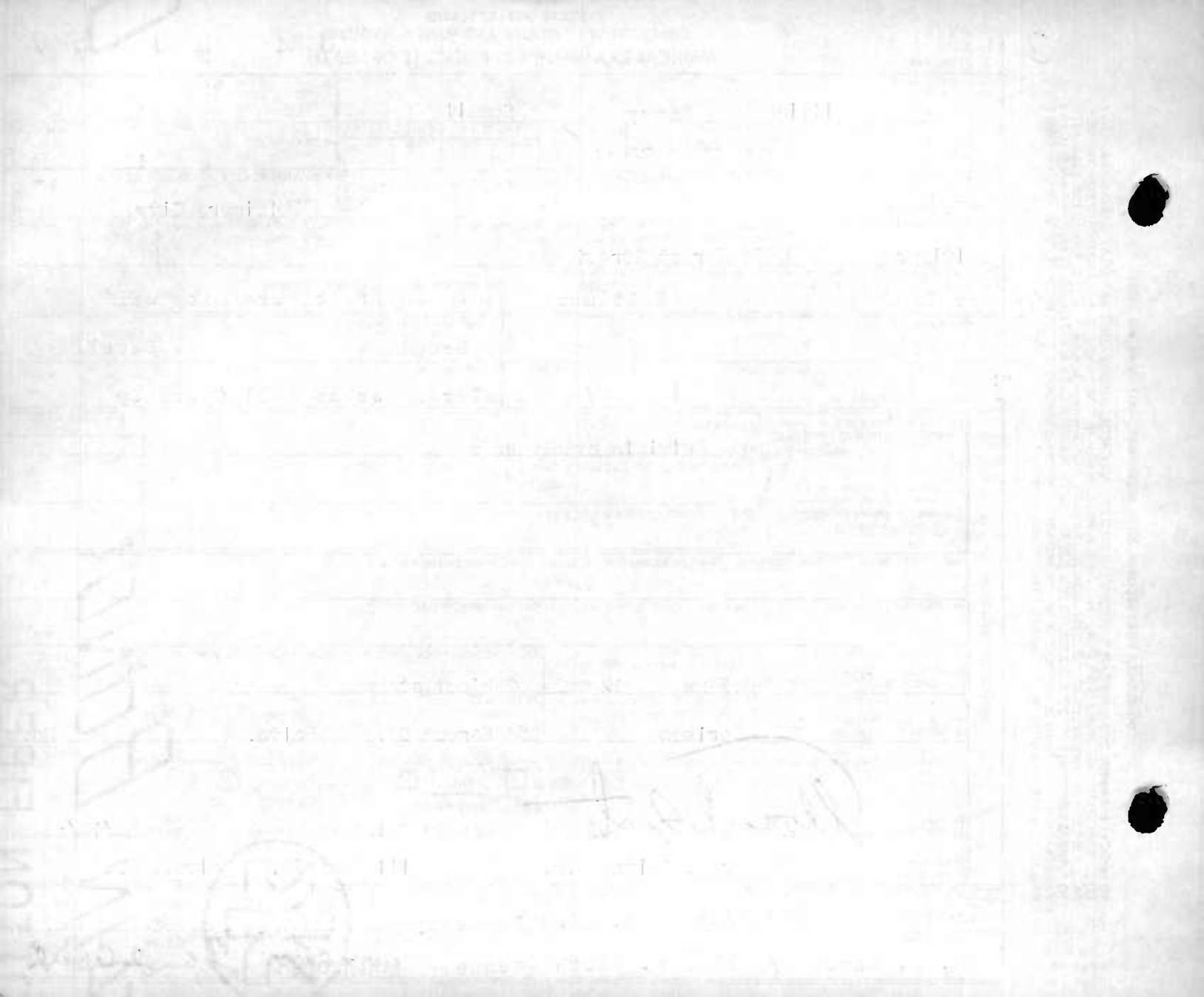
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO. 8 2 2 0 8 5 9   |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) William Henry Sewell   |  |   |  |   |  |   |  |   |  | 2b. HOUR M   |  |
| 3. SEX Male   |  | 4. RACE Negro   |  | 5. DATE OF BIRTH MONTH DAY YEAR 6 23 1938   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.   |  | 7. IF UNDER 1 YR. MONTHS DAYS             |  | 7. IF UNDER 24 HRS. HOURS MIN.   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7c. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> XX |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                                      |  | 2c. DATE PRONOUNCED DEAD 8 12 1982        |  | 2d. HOUR M 8:52 a  |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 954 Forest Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY         |  |  |  |
| 13a. STATE Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS Baltimore City Jail   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Knox  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Saddle Sewell                                      |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No   |  |   |  | 16b. SOCIAL SECURITY NO. N/A  |  | 17. INFORMANT ADDRESS Gloria Barber 4631 Clareway   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9660 IMMEDIATE CAUSE (a) Multiple stab wounds<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:30** 8 12 1982   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stabbed |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) prison  |  | 21f. LOCATION STREET 954 Forest St.   |  | CITY OR TOWN Balto.                       |  | COUNTY STATE Md.   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE  |  |   |  | TITLE (SPECIFY) M.D. Deputy Chief   |  |   |  | DATE SIGNED 8/12/82                       |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.   |  |   |  | ADDRESS 111 Penn St. Balto., MD.  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  |   |  | 23b. DATE 8/17/82   |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery  |  | 23d. LOCATION CITY OR TOWN Baltimore      |  | COUNTY STATE Co. Md.   |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101   |  |   |  |   |  | ADDRESS E. North Avenue   |  | 25a. DATE REC'D. BY REGISTRAR AUG 16 1982 |  | 25b. REGISTRAR'S SIGNATURE John J. Canine  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with any information with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical information should be furnished to the coroner.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |   |  |  | 8 2 2 0 8 6 0                  |  |
|--|--|---|--|---|--|--|---|--|--|--------------------------------|--|
| FOR<br>STATE<br>REGISTRAR  |  |   |  |   |  |  |   |  |  | REG. NO.                       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST<br>DAVID L SHACH                                     |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 / 18 / 82                                |   |  | 2b. HOUR<br>2 P.M.   |                                |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 22 22  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 74 HRS.<br>HOURS MIN. |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |   |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Md. Hosptl/9 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CONTRACTOR |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BUILDING  |                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5607 WOODCREST AVE. #21215  |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LOUIS SHACH  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SOPHIA CHAIKEN   |  |  |   |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII-ARMY 215-12-1760  |  | 17. INFORMANT MRS. JOYCE A. SHACH<br>5607 WOODCREST AVE. BALTO., MD 21215      |   |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest.<br>2169<br>DUE TO, OR AS A CONSEQUENCE OF*<br>(b) Fibrohistiocytoma<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |   |  |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Pleural effusion  |  |   |  |   |  |  |   |  |  |                                |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) |  |   |  |  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1982, to Aug 18, 1982, that (I) (we) lost<br>saw the deceased alive on Aug 13, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |                                |  |
| 22b. SIGNATURE<br>Lawrence Sigman MD   |  |   |  |   | DEGREE   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>8/28/82    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lawrence Sigman   |  |   |  |   | 22e. ADDRESS<br>225 Green St Baltimore Md.                                     |  |   |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  |   | 23b. DATE<br>AUG. 20, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>PETACH TIKVAH                            |  |   | 23d. LOCATION<br>ROSEDALE BALTO. MD  |  |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 24 1982                                   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver  |  |  |                                |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 0 8 6 1  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |   |  |  |
|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY E. SHAFFER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 22 82</b>                               |  |   | 2b. HOUR<br><b>8<sup>35</sup> P.M.</b>   |  |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 3, 1885</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS.                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                   |  |   |  |  |
| 11a. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Examiner</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Textile</b>   |  |  |
| 13a. STATE<br><b>Md.</b>   |   |   | 13b. COUNTY<br><b>-</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Yealey</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Penina Hess</b>                 |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>212 26 7305</b>  | 17. INFORMANT<br>ADDRESS<br><b>Genevieve Salfner same</b>                           |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC BLOCK.. CONGESTIVE HEART FAILURE.</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CORONARY SCLEROSIS.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>PLEURAL EFFUSION.</b>  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8.13.82</b> , 19 <b>82</b> , to <b>8.22</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>8.22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Anna Ferrari</b>  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8.22.82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANNA FERRARI</b>   |   |   |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>8/26/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Balto. Co. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Burgee Funeral Home 3631 Falls Road 21211</b>   |   |   |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>AUG 24 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 6 2

REG. NO.

|  |  |  |   |   |  |  |   |  |  |
|--|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MILDRED<br>MIDDLE B.<br>LAST SHANMAN  |  |  | 2a. DATE OF DEATH<br>MONTH 8<br>DAY 6<br>YEAR 82                |   | 2b. HOUR<br>11 p.m.  |  |   |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH MARCH<br>DAY 8<br>YEAR 1914   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>OHIO  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ACCOUNTS PAYABLE |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>ADVANCE BUSINESS MACH.  |  |
| 13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>BALTIMORE  |   | 13c. CITY OR TOWN<br>BALTIMORE                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST LOUIS<br>MIDDLE<br>LAST BLOCK   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST ROSE<br>MIDDLE<br>LAST NATHAN |   |  | 13e. STREET ADDRESS<br>1 SLADE AVE. APT. 107 (21208)                                 |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>250-62-5362                         |   | 17. INFORMANT<br>ADDRESS<br>MRS. ALAN ELKIN 3102 LIGHTFOOT DR. 21208 |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes Mellitus, Gout, Previous myocardial infarction</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><u>Diabetes Mellitus, Gout, Previous myocardial infarction</u> |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>4 days  |  |
|  |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>8/2/82</u> , 19 <u>82</u> , to <u>8/6</u> , 19 <u>82</u> , that (I) (we) saw the deceased alive on <u>8/6</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>David M. Diffley</u>  |  |  |   | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |   | 22c. DATE SIGNED<br>8/6/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David M. Diffley  |  |  |   | 22e. ADDRESS<br>301 W University Parkway Baltimore Md   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>AUGUST 8, 1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HAR SINAI CEM.  |  | 23d. LOCATION<br>OWNERS MILES<br>BALTIMORE BALD. MARYLAND                            |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN, MARYLAND (BALTIMORE) 21215   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 10 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Canish</u>                                  |   |  |  |

3007 28

911 23 3 8

1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

11000 12000 13000 14000 15000 16000 17000 18000 19000 20000

21000 22000 23000 24000 25000 26000 27000 28000 29000 30000

31000 32000 33000 34000 35000 36000 37000 38000 39000 40000

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
| REG. NO. 8 2 2 0 8 6 3  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WILLIAM SHARKEY</b>   |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR HOUR<br><b>8 26 82 10:10</b>                           |  |  |  |
| 3a. SEX<br><b>male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 3 05</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>77</b>                                       |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WAREHOUSEMAN</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Warehouse</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>A.A.</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>404 Irene Dr.</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Willaim Sharkey</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma N/A</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-4083</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. P. Spangenberg same as 13</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1460 IMMEDIATE CAUSE (a) Bleeding from Lt Carotid artery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of the tonsil</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 24, 19 82</b> , to <b>August 26, 19 82</b> , that (I) (we) lost saw the deceased alive on <b>August 26, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Bedri Yousif</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  |   |  | 22c. DATE SIGNED<br><b>8/26/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEDRI YOUSIF</b>  |  |  |  | 22e. ADDRESS<br><b>St Agnes Hosp<br/>Caton &amp; Wilkens Ave<br/>Baltimore, Md. 21229</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>28 Aug. 82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. MD.</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>James S. Kirkley F.H.</b>   |  |  |  | ADDRESS<br><b>Glen Burnie MD.</b>  |  | 25. DATE RECEIVED BY REGISTRAR<br><b>AUG 30 1982</b>                                    |  |  |  |



Continuation of the Survey of  
Bleeding from the Coronal artery



August 12 22 - August 12 22

BOSTON, MASS. 21-22  
JULY 21 1902  
JULY 22 1902

BED 1 YAGSIE  
Beds of Yagzie

July 21 1902

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>KATHERINE E. SHEPHERD</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 01 82</b>  |   | 2b. HOUR<br><b>6:10P<sup>M</sup></b>  |  |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 1 14</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                      |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Midtown Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Lady</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Lomars Clothes</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>817 N. Charles Street 21202</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert L. Woodward</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mollie A. Rutherford</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>234-01-7155</b>  |   | 17. INFORMANT ADDRESS<br><b>Wesley Wilson 1100 Plover Drive 21227</b>                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-11</b> 19 <b>80</b> , to <b>8-1-82</b> , that (I) (we) last saw the deceased alive on <b>7-27</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>R. Reider</b>   |  | DEGREE  |   | 22c. DATE SIGNED<br><b>8-1-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RUBEN REIDER M.D.</b>  |  | 22e. ADDRESS<br><b>1406 Annapolis Highway So. Suite 107</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/4/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cemetery</b>                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>AUG - 4 1982</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>  |  |   |   |   |  |

MEDICAL CERTIFICATION

99

1102 BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

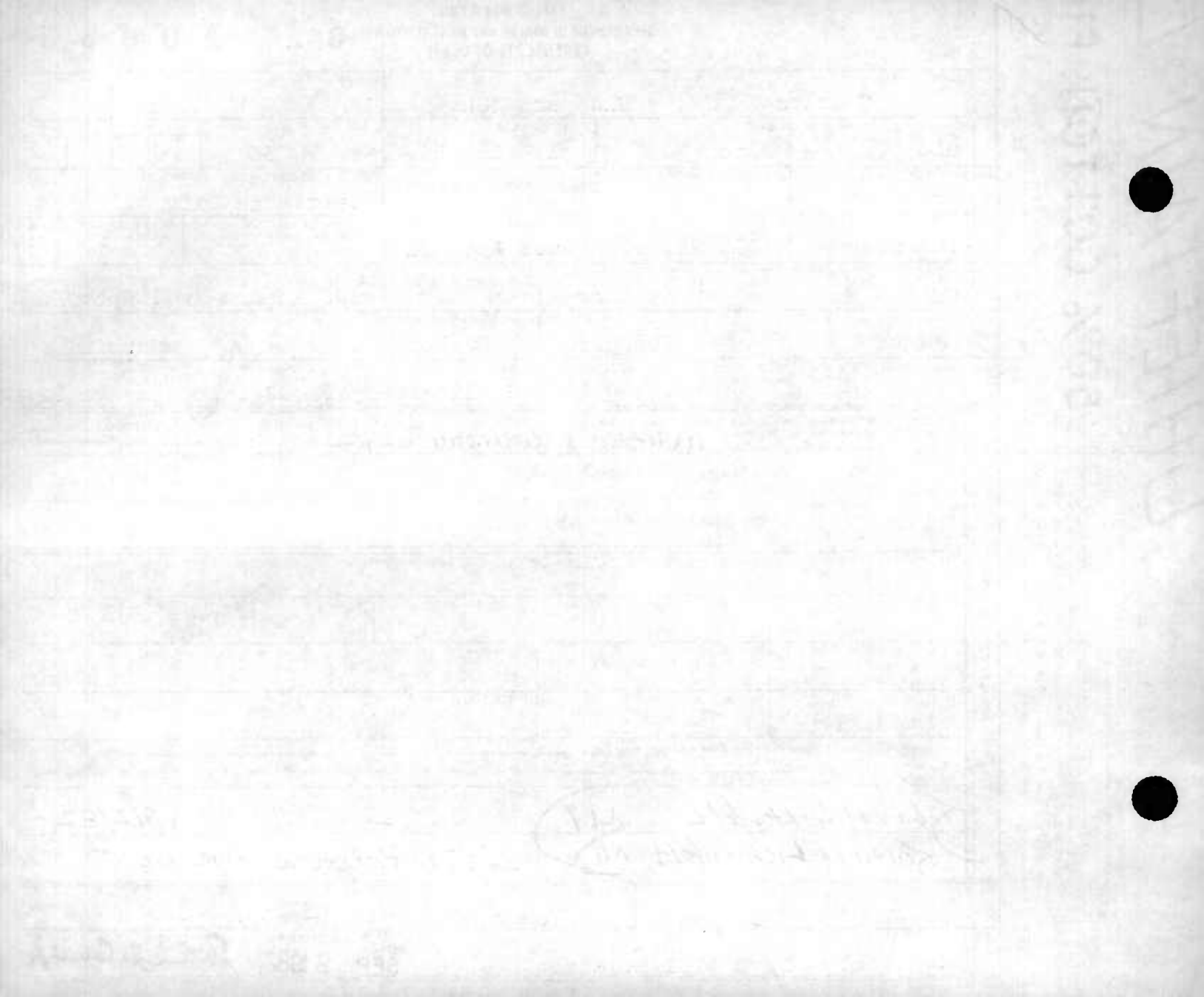
FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 6 5

REG. NO.

|  |  |   |  |  |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
|--|--|---|--|--|--|---|--|--------------------------|--|-----------------|--|-------|--|------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH        |  |                 |  | MONTH |  | DAY  |  | YEAR |  | 2b. HOUR |  |
| Charles R. Sheppard (Shepherd)   |  |   |  |  |  |   |  | 8                        |  |                 |  | 28    |  | 82   |  |      |  | M        |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS |  |       |  |      |  |      |  |          |  |
| Male   |  | Black   |  | 1 15 26  |  | 56 YRS.   |  | MONTHS                   |  | DAYS            |  | HOURS |  | MIN. |  |      |  |          |  |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| Maryland   |  | USA   |  |  |  | Baltimore City  |  |                          |  |                 |  |       |  |      |  |      |  | MD.      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| Baltimore  |  | 4305 Rogers Avenue Apt. F2  |  |  |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS      |  |                 |  |       |  |      |  |      |  |          |  |
| Maryland   |  |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4305 Rogers Ave. Apt. F2 |  |                 |  |       |  |      |  |      |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| James Sheppard   |  | Esther Corbin   |  |  |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| Yes  |  | 225-20-8026   |  | Shelia Sheppard  |  | 4305 Rogers Ave F2  |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic carcinoma lung</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |  |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  | 22b. SIGNATURE<br><u>Garen M. Lichtenfeld</u>   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>9/2/82  |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| Garen M. Lichtenfeld   |  | 2435 W. Belvedere Ave 21215   |  |  |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| BURIAL   |  | 9/2/82  |  | Md, Veteran Cem  |  | Crownsville Md  |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |
| Wm. C. March F/ H 1101 E. North avenue   |  | SEP 2 1982  |  | John J. Casper   |  |   |  |                          |  |                 |  |       |  |      |  |      |  |          |  |



RELEASED AS NON-MED DR. SMITH PER MR HENRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 6 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GLADYS SHEPPARD</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08/24/82</b>  |  | 2b. HOUR<br><b>7:44pm</b>                                |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT 11, 1932</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b><br>YRS. MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NURSE AIDE</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing Home</b> |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1017 VALLEY ST</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL SUMMERVILLE</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ESTELLA HOLMES</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213.30.3885</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>MRS. ELAINE STOKES 220N. WOLFE ST</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b><br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>respiratory arrest + asthma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>metastatic small cell carcinoma</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>asthma</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/24</b> , 19 <b>82</b> , to <b>8/24</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>8/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Robert I. Garver, Jr.</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>8/24/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT I. GARVER, JR.</b>  |  | 22e. ADDRESS<br><b>DEPT. OF MED<br/>JOHNS HOPKINS HOSP</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>B</b>   |  | 23b. DATE<br><b>8/28/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King m. pk</b>                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. CO. MD</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph C. Rues</b>   |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 3 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canick</b>   |   |  |  |



MEDICAL CERTIFICATION

29

1001 BP



Chicago, Ill. 11-19-35  
Dear Sir:  
Enclosed for you are two copies of a letterhead memorandum  
dated and captioned as above.  
Very truly yours,  
[Signature]  
[Name]  
[Title]  
[Address]

Very truly yours,  
[Signature]  
[Name]  
[Title]  
[Address]



NOV 20 1935

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 2 2 0 8 6 7   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| Olga C. SHERMAN  |  |   |  | August 6, 1982  |  |   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Female   |  | White   |  | Nov. 9, 1893  |  | 88 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland   |  | U.S.A.  |  |   |  | Baltimore City, MD  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |  | Garden Village Nursing Center   |  | Home maker  |  | -----   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  | -----   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS   |  |   |  |
| Charles Rusch  |  | Olga RUSCH  |  | 5012 Greenhill Avenue   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |   |  |
| no   |  | 217-54-7806   |  | Marie Shreaves 5012 Greenhill Avenue 21206  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>4292</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>weeks</u><br><u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>Cachexia; Anemia; Occult G.I. Bleeding; Multiple Strokes; Blind; Deaf.</u>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?         |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
|  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>4/2/67</u> to <u>8/6/82</u> , that (I) (we) last saw the deceased alive on <u>8/3/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Albert B. Bradley</u>   |  | DEGREE<br><u>M.D.</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>Aug 6, 1982                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Albert B. Bradley, M.D.   |  | 22e. ADDRESS<br>4900 Belair Road Baltimore, Maryland  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Aug 9, 82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Homes, Inc.   |  | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.   |  | 25. FILED BY REGISTRAR<br>AUG 10 1982 <u>John J. Carney</u>   |  |   |  |



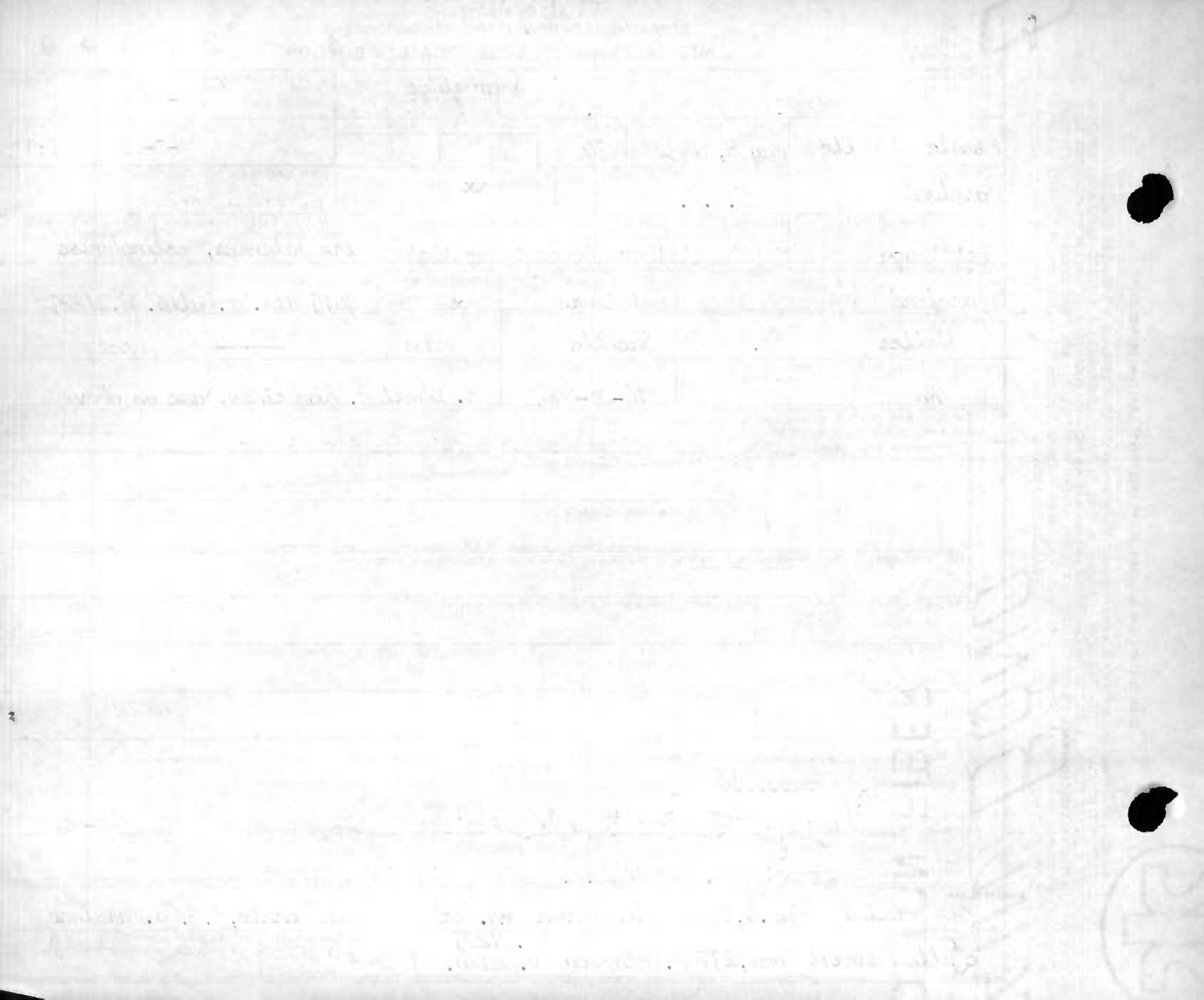


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |   |  |   |  | REG. NO. 20868   |  |   |  |
|--|--|------------------|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>AUDREY M. Shewbridge SHEWBRI DGE  |  |                  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>8-3-82 19                       |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 8, 1932  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br>50   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>8-3-82 19                      |  | 2d. HOUR<br>5:11A M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Wire Solderer, Westinghouse  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY      |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3615 4th. St. Balto. Md. 21225   |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter E. Shettle  |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Kratz  |  |   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>216-28-8467  |  | 17. INFORMANT<br>ADDRESS<br>Mr. Robert D. Shewbridge, Same as above                             |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>Margareta Prehrell   |  |                  |  | TITLE (SPECIFY)<br>Assistant   |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>8-3-82   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |  |                  |  | ADDRESS<br>111 Penn Street   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>Aug. 6, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park                                      |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A. Co. Maryland |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home, 337 E. Patapsco  |  |                  |  | ADDRESS<br>Md. 21225   |  | 25a. DATE REC'D BY REGISTRAR<br>AUG 06 1982   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Shier                                  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  | 8 2 2 0 8 6 9  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|
| FOR<br>1 - STATE REGISTRAR   |  |   |  |   |  |   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edward R Shipley</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 8, 1982</b>  |  |  |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 3, 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b><br>YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3430 Parklawn Ave</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Office Manager</b>                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Levin Chemical</b> |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>3430 Parklawn Ave</b>  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward C Shipley</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary F Kiely</b>  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-01-5860</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Carmel M Shipley Same</b>  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY HEMORRHAGE</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LUNG CANCER</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b><br><b>6 MONTHS</b> |  |   |  |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br>AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>15 JULY 1982</b> , to <b>PRESENT</b> , 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>4 AUGUST 1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did) (and not) view the body after death.   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Dolores M. Purnell MD</b>   |  |   |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10 AUG 82</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DOLORES M. PURNELL MD</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>COLUMBIA PROF. BLDG #102 COLUMBIA, MD 21044</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/12/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 10 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order to conduct an autopsy.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   | 8 2 2 0 8 7 0   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|---|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | CERTIFICATE OF DEATH  |  |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |   | 2a. DATE OF DEATH   |  |   |   | 2b. HOUR   |  |  |  |
| FIRST MIDDLE LAST<br>HARRY F. Shipley, Jr.   |  |   |  |   | MONTH DAY YEAR<br>8-18 82                                     |  |   |   | 6:05 AM  |  |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 1- 02  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                      |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. City MD.  |   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction                   |  |  |  |  |
| 13a. STATE<br>MD   |  |   |  |   | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>BALTO  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>522 St Paul St. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY F. Shipley   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA STOFFER |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>-NO-   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>220-05-0686                       |  | 17. INFORMANT<br>Mr. Daniel Shipley Upper Darby. PA<br>Pensel Apts. D11 State Rd. & Hazel Ave 19082 |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiovascular collapse<br>2089<br>DUE TO, OR AS A CONSEQUENCE OF (b) Extreme debilitation<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) Pre-Leukemia |  |   |  |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Periph. vascular disease, gangrene  |  |   |  |   |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/16 19 82, to 8/18 19 82, that (I) (we) last saw the deceased alive on 8/17 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>A. Reisinger MD  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>8/18/82   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. Reisinger MD   |  |   |  |   |   | 22e. ADDRESS<br>Mercy Hospital   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>8/20/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olive Cemetery      |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown Balt. MD |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Rd., Randallstown, MD 21133   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 20 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                        |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

BP

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |                                   |   |  |
|--|--|---|--|---|--|--|--|-----------------------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 8 2 2 0 8 7 1<br>REG. NO.   |  |   |  |  |  |                                   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR                          |   |  |
| FIRST MIDDLE LAST<br>MARGARET L SHOATES  |  |   |  |   | MONTH DAY YEAR<br>08 24 82   |  |  | HOURS MIN.<br>4 1/2 M             |   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | 7. IF UNDER 1 YEAR                |   |  |
| Female   |  | Black   |  | MONTH DAY YEAR<br>6 26 30   |  | 52 YRS   |  | IF UNDER 24 HRS                   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |                                   |   |  |
| N. Carolina  |  | USA   |  |   |  | CITY MD.   |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| BALTIMORE  |  | Provident Hospital  |  |   |  |  |  |                                   |   |  |
| 13a. STATE   |  |   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                                   | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |   |  |   |  |  | Baltimore  |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  |   |  |   | 15. MOTHER'S MAIDEN NAME   |  |  |                                   |   |  |
| FIRST MIDDLE LAST<br>David Hendrick  |  |   |  |   | FIRST MIDDLE LAST<br>Lucy Hunter   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS                                    |                                   |   |  |
| No   |  |   |  |   | 219-26-2358  |  | Barbara A. Patterson 2911 Rosalind                       |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) HYPOXIA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |  |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |   |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |                                   |   |  |
| 22a. I certify that at this hospital, attended the deceased from 8-12, 1982 to 8-24, 1982, that (1) <input checked="" type="checkbox"/> I saw the deceased on 8-24, 1982, and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |  |   |  |  |  |                                   |   |  |
| 22b. SIGNATURE<br>Isaiah Dimery  |  |   |  |   | 22c. DATE SIGNED<br>8-24-82  |  |  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   | 22e. ADDRESS   |  |  |                                   |   |  |
| ISAIAH DIMERY  |  |   |  |   | 2120 Liberty Hts   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |                                   |   |  |
| BURIAL   |  |   | 8/29/82  |   | Locust Grove Bapt.   |  | Wise, N.C.   |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  |   | 25a. DATE RECEIVED BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                               |                                   |   |  |
| Wm. C. March F/H 1101 E. North Avenue  |  |   |  |   | AUG 26 1982  |  | John J. Connel   |                                   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the official cause must be marked on page 1.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 7 2

REG. NO.

|   |  |                      |   |  |  |  |  |   |   |  |
|---|--|----------------------|---|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Carolyn</b> FIRST MIDDLE LAST <b>Short</b>   |  |                      | 2a. DATE OF DEATH MONTH DAY YEAR <b>8 7 82</b>  |  |  | 2b. HOUR <b>6:15 AM</b>  |  |   |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b> |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 11, 1893</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |   |  |
| 7a. BIRTHPLACE (CITY OR VILLAGE OR FOREIGN) <b>Washington D.C.</b>  |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>City Baltimore City MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Luthern Hospital</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD.</b>   |  |                      | 13b. COUNTY <b>Baltimore</b>  |  |  | 13c. CITY OR TOWN  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME (TYPE OR PRINT) <b>late Carl Lichtensels</b>  |  |                      | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>late Caroline Rosingarn</b>   |  |  | 13e. STREET ADDRESS <b>6811 Campfield Rd.</b>  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>No</b>  |  |                      | 16b. SOCIAL SECURITY NO. <b>578014188</b>   |  |  | 17. INFORMANT ADDRESS <b>21207</b>   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4860 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>BILATERAL PNEUMONIA (SEPSIS)</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>  |  |                      |   |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/6/82</b> , to <b>8/7/82</b> , that (I) (we) lost saw the deceased alive on <b>8/6/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |                      |   |  |  |  |  |   |   |  |
| 22b. SIGNATURE <b>N.S. ASHOK</b>  |  |                      | DEGREE  |  |  | 22c. DATE SIGNED <b>8-7-82</b>   |  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N.S. ASHOK</b>   |  |                      | 22e. ADDRESS <b>Luthern Hospital, Baltimore</b>   |  |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>   |  |                      | 23b. DATE <b>Aug 11, 1982</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l</b>  |  |   | 23d. LOCATION CITY OR TOWN STATE <b>Virginia</b>  |  |
| 24. FUNERAL DIRECTOR (NAME) <b>Harry H Witzke</b>   |  |                      | 25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1982</b>  |  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>   |  |   |   |  |

THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

6

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 0 8 7 3  
REG. NO.

|  |  |   |  |  |  |   |  |   |  |  |
|--|--|---|--|--|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>ELANDOR G SHORTER</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR <b>8-18-82</b>                      |  |  | 2b HOUR<br><b>1:30 P.M.</b>   |  |   |  |  |
| 3 SEX<br><b>FB</b>   |  | 4 RACE<br><b>NEGRO</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>1 25 12</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO MD</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                    |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3005 LAWING RD</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MEMORABLE</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>  |  |  |
| 13a STATE<br><b>MD</b>   |  |   | 13b COUNTY<br><b>BALTIMORE</b>   |  |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>  |  |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William GREENWOOD</b>  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mamie BROWN</b>     |  |  |   |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b SOCIAL SECURITY NO.  |  |  | 17 INFORMANT<br>ADDRESS<br><b>NATHAN SHORTER 3005 Lawing Rd</b>                     |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4149</b> IMMEDIATE CAUSE (a) <b>Sudden Death</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1971.</b>   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>—</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a   |  |   |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/16</b> , 19 <b>82</b> , to <b>8/18</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Lawrence Solomon MD</b>   |  |   | DEGREE   |  |  | 22c. DATE SIGNED<br><b>8-19-82</b>  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAWRENCE SOLOMON</b>   |  |   | 22e. ADDRESS<br><b>609 Reisterstown Rd.</b>                            |  |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>8/24/82</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD Nat Mon PA</b>                          |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                              |  |
| 24. FUNERAL DIRECTOR<br><b>Walter J. Lingo 631 N. Gilman St</b>  |  |   |  |  |  | 25. DATE REC'D BY REGISTRAR<br><b>AUG 23 1982</b>                                   |  | 25. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>  |  |  |

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Handwritten text, likely a letter or document, with a circular stamp or seal visible in the upper left corner. The text is mirrored across the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 0 8 7 4<br>REG. NO.   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MORDCHAI SHUALY</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>AUGUST 1, 1982</b>   |  | 2b. HOUR<br><b>8:30 AM</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>OCTOBER 9, 1922</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>59 YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>HUNGARY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5807 PARK HEIGHTS AVENUE</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>JOURNALIST</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NEWSPAPER</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ISAAC SHUALY</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SARAH UNKNOWN</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>134-34-7264</b>  |  | 17. INFORMANT ADDRESS<br><b>MRS. FRIEDA SHUALY - 5807 PARK HEIGHTS AVE. #21215</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Renal Failure on Hemodialysis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5850</b>   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>about</b> 19 <b>78</b> , to <b>Aug. 1, 1982</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>about July 15, 1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>J. B. Zachary, M.D.</b>  |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                     |  | 22c. DATE SIGNED<br><b>AUGUST 1, 1982</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. B. ZACHARY</b>   |  |   |  | 22e. ADDRESS<br><b>4940 EASTERN AVENUE BALTIMORE, MD.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)<br><b>REMOVAL-BURIAL</b>  |  | 23b. DATE<br><b>AUG. 2, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ZICHRON MEIR</b>   |  | 23d. LOCATION (CITY OR TOWN) COUNTY STATE<br><b>BNAI BERAK, ISRAEL</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS. INC.</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>AUG - 5 1982</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |

10/10/10



10/10/10

10/10/10

10/10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   | 8 2 2 0 8 7 5<br>REG. NO.   |   |
|--|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ISRAEL SOL SHUMAN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-23-82</b>   |   | 2b. HOUR<br><b>5 P M</b>  |
| 3. SEX<br><b>M ALE</b>   | 4. RACE<br><b>CAUC.</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 31, 1921</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ADVERTISING</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PHONE CO.</b>           |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  | 13b. CITY OR TOWN<br><b>BALT</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br><b>6 RUSSERN CT., APT. T-2 #21215</b>                                |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MORRIS SHUMAN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JENNIE STEINER</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-12-8439A</b>  |   | 17. INFORMANT<br><b>HARRY SHUMAN</b> ADDRESS<br><b>6905 REISTERSTOWN RD. 1st FL. #21215</b> |   |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) CARDIAC ARREST</b>   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |   |   | (b) <b>R/O MI &amp; ARRHYTHMIA</b>                              |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |   | (c)   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>PATUITARY ADENOMA</b>   |  |  |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO        |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>8/23</b> , 19 <b>82</b> , to <b>8/23</b> , 19 <b>82</b> , that (we) lost saw the deceased alive on <b>8/23</b> , 19 <b>82</b> , and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death. |  |  |   |   |   |
| 22b. SIGNATURE<br><b>PATRICIA A. SWELLO</b>  |  | DEGREE<br><b>SNELL M.D.</b>  |   | 22c. DATE SIGNED<br><b>8/23/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICIA A. SWELLO</b>   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>AUG. 25, 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH YEHUDA ANSHE KURLAND</b>                      |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |  |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 26 1982</b>   |   |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 7 6

REG. NO.

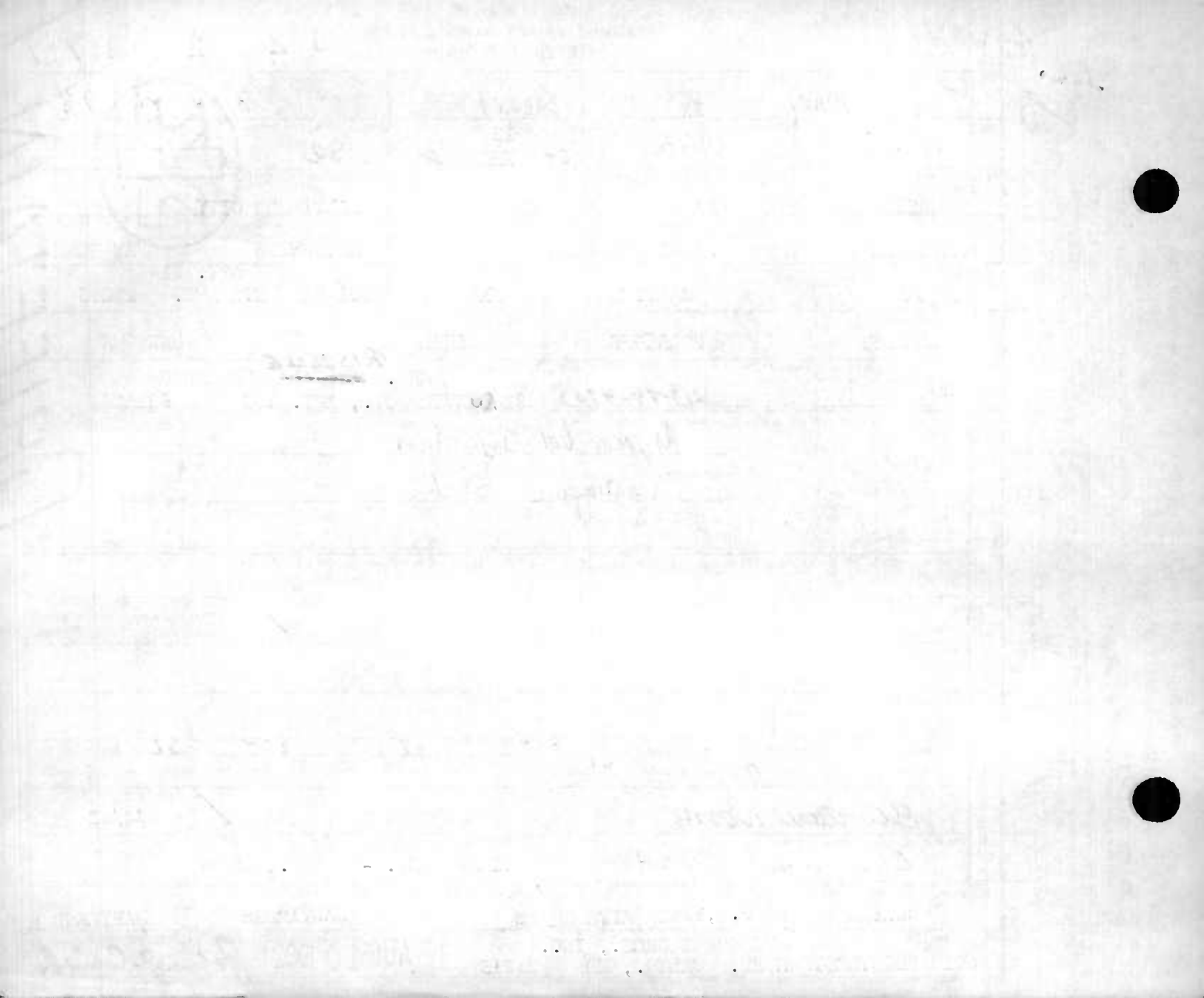
|   |  |   |  |   |                            |   |  |  |  |                                |  |
|---|--|---|--|---|----------------------------|---|--|--|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frank Anthomy Sica</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-9-82</b> |   | 2b. HOUR<br><b>9:30 AM</b> |   |  |  |  |                                |  |
| 3 SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 5, 1907</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                 |  |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Agnes Hospital</b> |  |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired credit manager</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>406 Swann Ave., 21229</b>  |  |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>late Joseph Sica</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>late Angela Cirullo</b>   |                            |   |  |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218 12 6727</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Rose Marie Sica 406 Swann Ave., Balto</b>  |                            |   |  |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Adenocarcinoma to the liver.</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |                            |   |  |  |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |  |   |                            |   |  |  |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |                            |   |  |  |  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |  |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-8-82</b> to <b>8-9-82</b> , that (I) (we) last saw the deceased alive on <b>8-9-82</b> at <b>9:30 AM</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                            |   |  |  |  |                                |  |
| 22b. SIGNATURE<br><b>Kaushalendra K. Singh</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |                            |   |  | 22c. DATE SIGNED<br><b>8-9-82</b>  |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KAUSHALENDRA K. SINGH M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL.</b>  |                            |   |  |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Aug 13, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St James</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodbridge New Jersey</b>                        |  |  |  |                                |  |
| 24. FUNERAL DIRECTOR<br><b>HARRY H WITZKE</b>   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>AUG 10 1982</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>  |  |  |  |                                |  |



**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 0 8 7 7<br>REG. NO.   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MAY R Siegel   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 4 82   |  |  |  | 2b. HOUR<br>9 3/4   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 XXX 00   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA   |  | 8b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                        |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS<br>APT. 314<br>6101 PARK HTS AVE. 21215  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BARNETT POLAKOFF  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RISEL UNKNOWN  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>213-74-4703   |  | 17. INFORMANT<br>MRS. RISELLE NERENBERG<br>31 RUXVIEW CT., APT. 102 #21204  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Cardiac Shock<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8-4 19 82 to 8-4 19 82 that (I) (we) last saw the deceased alive on 8-4 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Elio Raul Novoa   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>8/4/82   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elio Raul Novoa  |  |   |  | 22e. ADDRESS<br>SINAI HOSP. - BALTO., MD  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>AUG. 6, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>AITZ CHAIM  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 10 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |   |  |

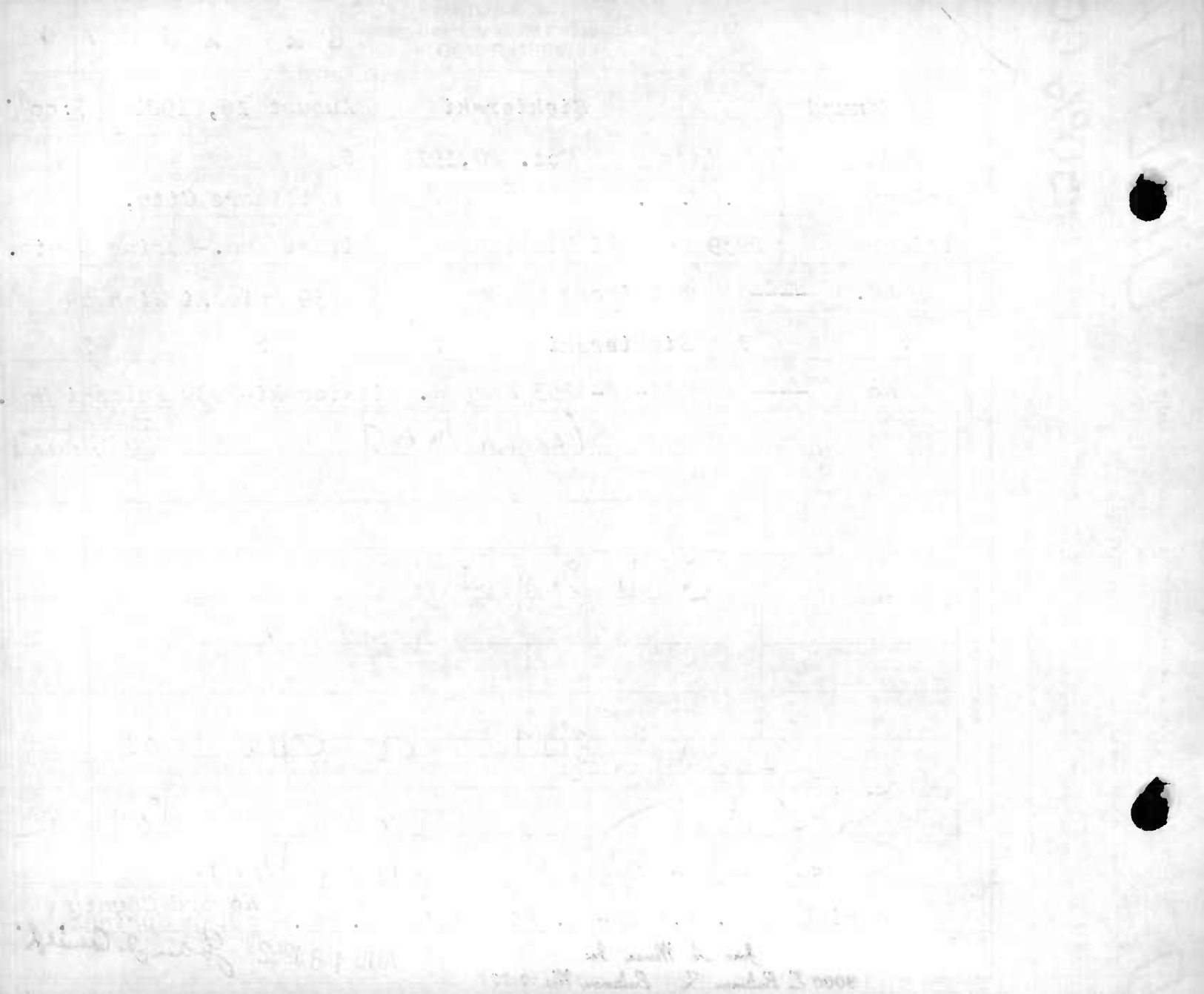


DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 7 8

REG. NO.

|   |  |   |   |  |   |   |   |  |  |
|---|--|---|---|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edmund Siekierski</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 16, 1982</b>                                   |  |   | 2b. HOUR<br><b>7:00 A.M.</b>  |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 20, 1912</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Poland</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                 |   |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS)<br><b>2939 Pulaski Highland</b> |   |  |   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Diesel Eng.-Marine Equip.</b> |   | 15. KIND OF BUSINESS OR INDUSTRY   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>-----</b> 13c. CITY OR TOWN <b>Baltimore</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2939 Pulaski Highway</b>  |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>Siekierski</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>?</b>                        |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>081-12-3253</b>                   |  | 17. INFORMANT<br>ADDRESS<br><b>Mary M. Siekierski-2939 Pulaski Hgwy</b>                       |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sudden Death</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Sudden Death</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Sudden Death</b> |  |   |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5/27 19 82</b>                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>8/16</b> |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>82</b>             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>82 8/16 82</b>                        |   |   |  |  |
| 22. I certify that (I) this hospital attended the deceased from <b>5/27</b> 19 <b>82</b> to <b>8/16</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>22 July</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |   |   |  |  |
| 22a. SIGNATURE<br><b>John Wm Eickborn</b>   |  |   | DEGREE  |  |   | 22b. DATE SIGNED<br><b>8-16-82</b>  |   | 22c. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Wm Eickborn</b>  |  |   | 22e. ADDRESS<br><b>Wm H. P.</b>   |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Aug. 18, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Michael's Ch. Cem.-Poplar Springs, Md.</b>       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard County, Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John A. Moran, Inc.</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 18 1982</b>   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>  |   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed with the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a funeral-transit permit. This permit, along with the carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 7 9

REG. NO.

|   |  |  |  |   |   |   |   |
|---|--|--|--|---|---|---|---|
| 1- FOR STATE REGISTRAR  |  | 1 DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN SIEMINSKI SR.</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 3, 1982</b>  |   | 2b. HOUR<br><b>10:20 AM</b>   |   |
| 3 SEX<br><b>M</b>   | 4 RACE<br><b>W</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9/30/22</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |   |   |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CORK &amp; SEAL</b> |   |   |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO</b>  | 13c. CITY OR TOWN<br><b>FRST PONT</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK SIEMINSKI</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE FUSCH</b>   |  |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 21903 0583</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>IDA SIEMINSKI ABOVE</b>  |   |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1930</b><br>IMMEDIATE CAUSE (a) <b>Cardiovascular arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic thyroid carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>13 years</b>  |  |  |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/26</b> , 19 <b>82</b> , to <b>8/3</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>8/3/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |
| 22b. SIGNATURE<br><b>Daniel P. Sulmasy</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8/3/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SULMASY</b>   |  | 22e. ADDRESS<br><b>Dept of Medicine - Johns Hopkins Hospital</b>   |  |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8/6/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANIS LAUS</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>   |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>   |  | ADDRESS<br><b>300 MACE</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG - 4 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Natten</b>   |   |



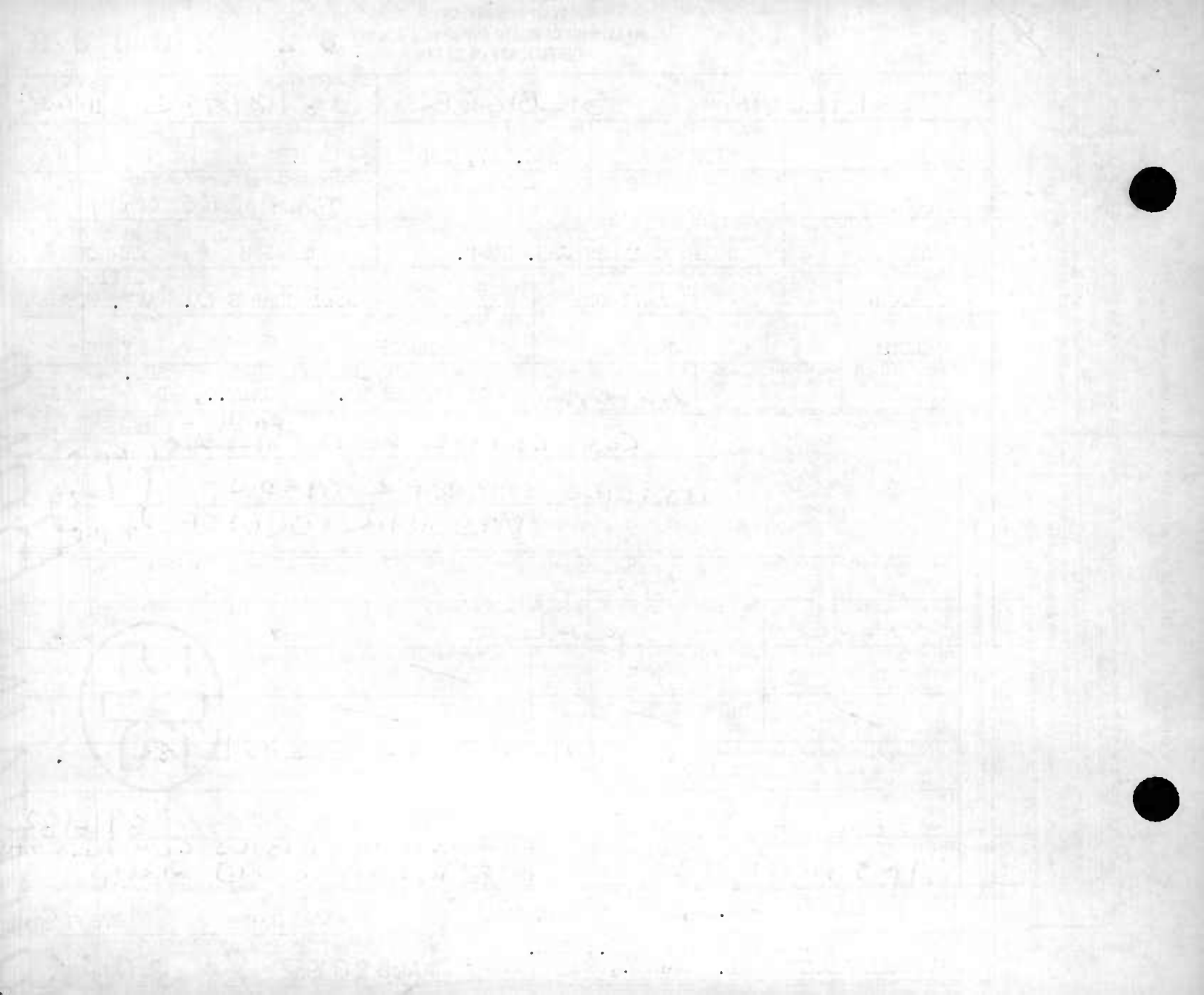
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 0 8 8 0<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>LILLIAN SILBINGER  |  |   |  | 2b. HOUR 11:40 A.M.   |  |  |  |
| 3. SEX FEMALE  |  | 4. RACE WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>DEC. 27, 1906  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.   |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GEN. HOSP. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME  |  |
| 13a. STATE MARYLAND  |  |   |  | 13b. COUNTY BALTIMORE   |  | 13c. STREET ADDRESS 3601 CLARKS LA. APT. 809   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST MORRIS JOHNSON   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLYE MEYERS  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  |   |  | 16b. SOCIAL SECURITY NO. 216-48-3049  |  | 17. INFORMANT JEROME SILBINGER APT. 809 3601 CLARKS LA. BALTO., MD 21215   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE<br>4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIO-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. VASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH } 10x } long } time |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) NONE  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION NONE  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 07/27/1982, to 08/16/1982, that (I) (we) lost saw the deceased alive on 08/16/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE D.R. Aug 18 MD  |  |   |  | DEGREE  |  | 22c. DATE SIGNED 8/16/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANSARI MD  |  |   |  | 22e. ADDRESS NORTH CHARLES GEN. HOSP. BALTIMORE MD 21215  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  | 23b. DATE AUG. 18, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND   |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  | 25a. DATE REC'D. BY REGISTRAR AUG 20 1982   |  | 25b. REGISTRAR'S SIGNATURE John J. Givich  |  |



STATE OF MARYLAND

1 - FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 8 1  
REG. NO.

|   |  |   |               |   |                   |   |       |  |      |  |  |
|---|--|---|---------------|---|-------------------|---|-------|--|------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE        | LAST  | 2a. DATE OF DEATH |   | MONTH | DAY  | YEAR | 2b. HOUR   |  |
| Vernon  |  | Silvers   | (Silver), Jr. |   | 8                 |   | 1     | 82   |      |  |  |
| 3. SEX  |  | 4. RACE   |               | 5. DATE OF BIRTH  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)   |       | 7. IF UNDER 1 YEAR   |      | IF UNDER 24 HRS.   |  |
| Male  |  | Black   |               | MONTH DAY YEAR<br>1 15 32   |                   | 50 YRS.   |       | MONTHS DAYS  |      | HOURS MIN.   |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 9b. CITIZEN OF WHAT COUNTRY?  |               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |       |  |      |  |  |
| Md.   |  | USA   |               |   |                   | Baltimore City MD   |       |  |      |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |               |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |       | 12b. KIND OF BUSINESS OR INDUSTRY  |      |  |  |
| Balto.  |  | 319 E. 21st St.   |               |   |                   |   |       |  |      |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |               |   |                   |   |       |  |      |  |  |
| 13a. STATE  |  | 13b. COUNTY   |               | 13c. CITY OR TOWN   |                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 13e. STREET ADDRESS  |      |  |  |
| Md.   |  |   |               | Balto.  |                   |   |       | 319 E. 21st St.  |      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |                   |   |       |  |      |  |  |
| Vernon Silvers Sr.  |  |   |               | Lillian France  |                   |   |       |  |      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |               | 17. INFORMANT   |                   | ADDRESS   |       |  |      |  |  |
| Yes   |  | 213-28-8607   |               | Lucy Rogers   |                   | 319 E. 21st Street  |       |  |      |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) HYPOXIA, RESP ARREST<br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>(b) CA LUNG<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(c) LUNG ATLECTASIS |  |   |               |   |                   |   |       |  |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>SEVERAL MONTHS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |               |   |                   |   |       |  |      |  |  |
|   |  |   |               |   |                   |   |       |  |      |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |               |   |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |      |  |  |
|   |  |   |               |   |                   |   |       |  |      |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                   |   |       |  |      |  |  |
|   |  |   |               |   |                   |   |       |  |      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                   |   |       |  |      |  |  |
|   |  |   |               |   |                   |   |       |  |      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/20, 19 82, to 7/22, 19 82, that (I) (we) lost saw the deceased alive on 7/22, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.                       |  |   |               |   |                   |   |       |  |      |  |  |
| 22b. SIGNATURE<br>Vincent A. Di Pietro MD   |  |   |               | DEGREE<br>MD  |                   |   |       | 22c. DATE SIGNED   |      |  |  |
|   |  |   |               | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                   |   |       |  |      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>V.D. PIETRO  |  |   |               | 22e. ADDRESS<br>Union Mem. Hosp.  |                   |   |       |  |      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>8-5-82   |               | 23c. NAME OF CEMETERY OR CREMATORY<br>Crest Lawn Cemetery   |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sikesville Md.                                    |       |  |      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H 1101 E. North Ave.   |  |   |               | 25a. DATE REC'D. BY REGISTRAR<br>AUG - 4 1982   |                   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |       |  |      |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer, and page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 20882   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Anna V. Simms  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>8 5 19 82   |  | 2b. HOUR<br>M  |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 26 1896  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>85 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                       |  | 2c. DATE PRONOUNCED DEAD<br>8 5 19 82   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5638 Woodmont Avenue |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5638 Woodmont Ave.                        |  |   |  |
| 14. FATHER'S NAME<br>MIDDLE LAST<br>William Alvey   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Neilson                                   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>216-01-2826   |  | 17. INFORMANT ADDRESS<br>Bonnie A. Kirkpatrick 4708 Anntana Ave.                                |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.   |  |  |  | TITLE (SPECIFY)<br>Deputy Chief   |  |   |  | DATE SIGNED<br>8/5/82  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |  |  | ADDRESS<br>111 Penn St. Balto., MD.   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>Aug. 9, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG - 6 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine                     |  |   |  |





100-370

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |   |
|---|--|--|--|---|--|---|--|--|---|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |   |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |   |
| REG. NO. 8 2 2 0 8 8 3  |  |  |  |   |  |   |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Frieda SIMPSON   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>August 3, 1982  |   | 2b. HOUR<br>10:41 <sup>a</sup> M   |  |   |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct 12, 1900  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>81 YRS                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                         |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |   |
| 13a. STATE<br>Maryland  |  |  |  |   | 13b. CITY OR TOWN<br>Baltimore   |   | 13c. STREET ADDRESS<br>6811 Campfield Road   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>late Philip   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>late Gerwig   |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 10 9232   |  | 17. INFORMANT<br>ADDRESS<br>21207<br>Augsburg Luthern Home 6811 Campfield Rd  |  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE A. Gangrene of small bowel, to discrete of small bowel with<br>1533<br>infarction and peritonitis.<br>B. Adenocarcinoma of rectosigmoid colon, with pericolic<br>abscess. C. Arteriosclerotic cardiovascular disease. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |
| 22a. I certify that (X) (this hospital) attended the deceased from July 28, 19 82, to August 3, 19 82, that (X) (we) last saw the deceased alive on August 3, 19 82, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.                       |  |  |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br>Michael A. Hyle M.D.  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>8/3/82   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael A. Hyle, M.D.  |  |  |  |   | 22e. ADDRESS<br>c/o Maryland General Hospital  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE<br>Aug. 6, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland              |  |  |   |
| 24. FUNERAL DIRECTOR<br>Harry H Witzke 4112 Columbia Rd Ellicott City   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG - 6 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |  |   |

0000 BP 9



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |  |
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.                                   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILLIAM SIZEMORE, SR.  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 7 82 |  |  |  |  | 2b. HOUR<br>9 <sup>10</sup> P.M.             |
| 3. SEX<br>M   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 30 39  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |
| 7. BIRTHPLACE (STATE OR FOREIGN)<br>W. VA.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD                               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALT. CITY HOSP |  |   |  | 12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE)<br>PAINTER                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CONSTRUCTION  |  |  |
| 13a. USUAL RESIDENCE (IF HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>Balt   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1617 DARTFORD RD. 21220   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ROY B. SIZEMORE  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SADIE MASSEY  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>N/A  |  | 17. INFORMANT (MOTHER)<br>SADIE SIZEMORE   |  | ADDRESS<br>2 MACDILL RD.<br>BALTO. MD. 21220 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br>5728<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RENAL FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>LIVER FAILURE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>  |  |   |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 8/5, 19 82, to 8/7, 19 82, that (I) (we) last saw the deceased alive on 8/7, 19 82, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Robert A. Weisgram MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>8/7/82   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT A. WEISGRAM   |  |   |  | 22e. ADDRESS<br>BALT. CITY HOSPITAL   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>8/13/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PINE GROVE CEM.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>RAVENSCLEIFF W. VA.                       |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>E. BARNES  |  |   |  | ADDRESS<br>FLEMING FUNERAL SERVICE 21018 BENSON, MD   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 9 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 2 0 8 8 5

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frank X. Slaysman</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Aug 14 1982</b> |   |  | 2b. HOUR<br><b>8:25 A.M.</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 11 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Baltimore City Hospital<br/>MASON F. LORD BLDG.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Insurance Broker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Rosedale</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1207 North 63rd St</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>XXXXXXXX William A Slaysman</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Powers</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 11</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs Hulda M Slaysman</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Same</b>  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>5850 Cardio-respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Minutes</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>Years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Blair J. Andrew MD</b>  |  |   |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Aug 14, 1982</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Blair J. Andrew MD.</b>  |  |   |   | 22e. ADDRESS<br><b>Baltimore City Hospital</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/17/72</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens Of Faith</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 2 2 0 8 8 6<br>REG. NO.  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <b>HENRY</b> MIDDLE <b>CHARLES</b> LAST <b>SLITZER</b><br><b>HENRY C. SLITZER</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>AUGUST</b> DAY <b>17</b> YEAR <b>1982</b>                         |  | 2b. HOUR<br><b>12:46 PM</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>NOV.</b> DAY <b>22</b> YEAR <b>1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHARLES GEN'L HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>INSPECTOR</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LOCAL GOV'T.</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>MARYLAND</b> COUNTY <b>BALTO.</b> CITY OR TOWN <b>BOWLEYS QTRS.</b>   |  |  |  |   |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13c. STREET ADDRESS<br><b>3733 CLARKS POINT RD. 21220</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>HENRY</b> MIDDLE <b>JOHN</b> LAST <b>SLITZER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LOUISE</b> MIDDLE <b></b> LAST <b>BISCOE</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>   |  | 17. INFORMANT<br><b>DOROTHEA C. SLITZER (WIFE)</b>  |  | ADDRESS<br><b>(SAME AS 13c)</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4512 IMMEDIATE CAUSE (a) Pulmonary emboli</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Phlebitis right leg</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>Cancer of Bladder with metastases</b>  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 16, 1982</b> , to <b>August 17, 1982</b> , that (I) (we) last saw the deceased alive on <b>August 17, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>C. VERGARA</b> M.D.   |  |  |  |   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8-17-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. VERGARA - SOARES</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>N. CHARLES GEN. HOSP. BALT. MD. 21218</b>                                    |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>CREMATION</b>  |  | 23b. DATE<br><b>10/18/1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CREMATORY</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MARYLAND</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>WALTER BROOKS BRADLEY INC. DUNDALK MD 21222</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 20 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |  |  |





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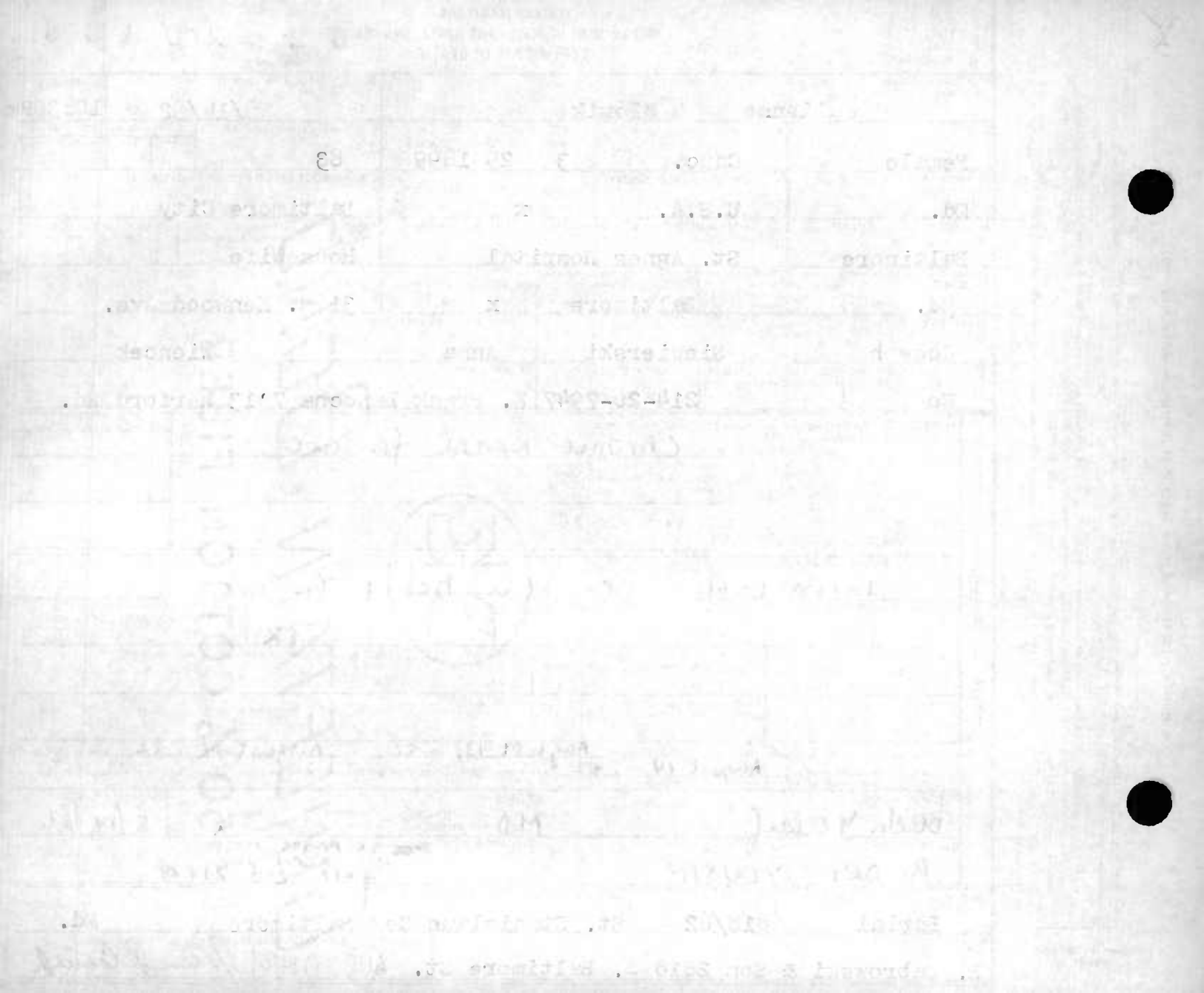
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |                                  |  |  |   |  |
|---|--|--|--|--|----------------------------------|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 8 2 2 0 8 8 8                    |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  |  |   |  |
| Julianna Slowik   |  |  |  |  | 8/14/82                          |  |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7b. HOUR  |  |
| Female  |  | Cauc.  |  | 3 29 1899  |                                  | 83 YRS.  |  | 10:30 PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Md.   |  | U.S.A.   |  |  |                                  | Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore   |  | St. Agnes Hospital   |  |  |                                  | Housewife  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |
| Md.   |  |  |  | Baltimore  |                                  |  |  | 31 N. Kenwood Ave.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |                                  |  |  |   |  |
| Joseph Siewierski   |  |  |  | Anna Wienczek  |                                  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT ADDRESS  |  |   |  |
| No  |  |  |  | 214-20-7947  |                                  | N. Frank Lanocha 7913 Harford Rd.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Renal failure</u><br>5850<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |                                  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Intractable Congestive heart failure</u>   |  |  |  |  |                                  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                  |  |  |   |  |
|   |  | P.M. 19  |  |  |                                  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                  |  |  |   |  |
|   |  |  |  |  |                                  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 13, 1982</u> , to <u>August 14, 1982</u> , that (I) (we) last saw the deceased alive on <u>August 14, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |                                  |  |  |   |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |                                  |  |  | 22c. DATE SIGNED  |  |
| Bedri Yousif  |  |  |  | M.D.   |                                  |  |  | 8/14/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |                                  |  |  |   |  |
| BEDRI YOUSIF  |  |  |  | 900 St Agnes Hosp.<br>900 CATEN AVE.<br>Baltimore Md 21229   |                                  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| Burial  |  | 8/18/82  |  | St. Stanislaus Cem   |                                  | Baltimore  |  | Md.   |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |                                  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| B. Dabrowski & Son 2818 E. Baltimore St.  |  |  |  | AUG 20 1982  |                                  | John J. Conner   |  |   |  |





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician within 72 hours of death. The law also requires that the death certificate be signed by the attending physician within 72 hours of death. The law also requires that the death certificate be signed by the attending physician within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
| REG. NO.   |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| MABEL P. SLOWIKOWSKI   |  |  |  |   |  | AUGUST 14, 1982  |  | 10:00A   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR   |  |
| Female   |  | White  |  | Feb. 22, 1908   |  | 74 YRS   |  | MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| N. Carolina  |  | U.S.A.   |  |   |  | BALTIMORE CITY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| BALTIMORE  |  | THE JOHNS HOPKINS HOSPITAL   |  |   |  | Housewife  |  |  |  |
| 13a. STATE   |  |  |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Maryland   |  |  |  |   |  | Baltimore  |  | Baltimore  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |
| John Ivey West   |  |  |  | Mary Lee Bailey   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |  |  |
| No   |  |  |  | 246-26-4368   |  | Mr. Henry F. Slowikowski, 431 S. Durham St. 21231                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RECURRENT OVARIAN CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>STAGE III MACROMETASTATIC CARCINOMA</u>                           |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8/14/82</u><br><u>8/82</u><br><u>3/82</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  |
|  |  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 2, 19 82</u> , to <u>August 14, 19 82</u> , that (I) (we) last saw the deceased alive on <u>August 14, 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Stanford L. Walker M.D.</u>   |  |  |  |   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |  | 22e. ADDRESS   |  | 8/14/82  |  |
| STANFORD L. WALKER, M.D.   |  |  |  |   |  | 600 N. WOLFE ST. BALTO., MD. 21205   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| Burial   |  |  |  | Aug. 17, 1982   |  | Oak Lawn Cemetery  |  | Baltimore, County Maryland   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |
| M.F. Sadowski & Sons, 1808 Eastern Avenue 21231  |  |  |  |   |  | AUG 16 1982  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 0 8 9 0   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>John R. Small   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 21 82   |  | 2b. HOUR<br>3:10 AM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept 13 1901   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>80   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Edgewood N. H. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Claims Mgr.  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Insurance   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br>Md.  |  |  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Charles Small  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Harriett Underwood  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>578-01-2492  |  | 17. INFORMANT ADDRESS<br>Richard L. Small Rocky River, Ohio   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral infarction</u><br>4349<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic CV Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>5+ years |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 20</u> , 19 <u>82</u> , to <u>Aug 21</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Aug 20</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Frederick J. Vollmer, MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>8-21-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FREDERICK J. VOLLMER MD  |  |  |  | 22e. ADDRESS<br>6100 YORK RD BALTIMORE MD 21212   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>8-23-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadow Mem Pk.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Howard Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co., Balto., Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 23 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   |   |  |   |  |   |  |                           |
|---|--|---|---|---|--|---|--|---|--|---------------------------|
| 8 2 2 0 8 9 1<br>CERTIFICATE OF DEATH   |  |   |   |   |  |   |  |   |  |                           |
| REG. NO.  |  |   |   |   |  |   |  |   |  |                           |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LOUIS James SMALLWOOD</b>   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8-8-1982</b>  |   |  |   |  | 2b. HOUR<br><b>1:00AM</b> |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1-10-1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                 |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GRANITE, MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                  |  |   |  |                           |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BARBER</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                           |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  |   |   |   | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                            |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |                           |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN SMALLWOOD</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>GERTRAUDE</b>   |   |  |   |  |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES)<br><b>WWII 24809-1766</b>   |   | 17. INFORMANT ADDRESS<br><b>BERNICE SMALLWOOD 3207 YONDAWMIN AVE</b>  |  |   |  |   |  |                           |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Prostatic carcinoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>1850</b> |  |   |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>few days</b><br><b>5 months</b><br><b>4 yrs</b> |                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |   |  |   |  |   |  |                           |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |                           |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |                           |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |   |  |                           |
| 22b. SIGNATURE <b>[Signature]</b>   |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>8/8/82</b>   |  |                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. SINCH.</b>   |  |   |   |   | 22e. ADDRESS<br><b>Dept. of Medicine, St. Agnes Hospital Baltimore</b>   |   |  |   |  |                           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>8-12-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD VETERANS</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>CROWNSVILLE MD</b> |   |  |                           |
| 24. FUNERAL DIRECTOR NAME<br><b>William R. Simpson</b>  |  |   |   |   | 25a. DATE RECD. BY REGISTRAR<br><b>AUG 09 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>              |   |  |                           |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 9 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |  |  |                          |
|--|--|---|---|---|--|--|--|--------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ANDREW E SMITH</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 10 82</b> |   |  | 2b. HOUR<br><b>6 1 M</b>   |  |                          |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>C 1</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 19 14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  |                          |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                  |  |                          |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV. OF MARYLAND</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING AGE)<br><b>Foreman B &amp; Railroad</b> |  | 12b. KIND OF BUSINESS OR |

|   |  |                              |  |                                      |  |  |  |  |  |
|---|--|------------------------------|--|--------------------------------------|--|--|--|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |  | 13b. COUNTY<br><b>Howard</b> |  | 13c. CITY OR TOWN<br><b>ELLICOTT</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8075 OLD MONTGOMERY RD</b> |  |
|---|--|------------------------------|--|--------------------------------------|--|--|--|--|--|

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 14. FATHER'S NAME<br>14a. FIRST<br><b>late John H. Smith Sr.</b> |  |  |  | 15. MOTHER'S MAIDEN NAME<br>15a. FIRST<br><b>late Alice E Leichter</b> |  |  |  |
|--|--|--|--|--|--|--|--|

|  |  |                          |  |  |  |  |  |
|--|--|--------------------------|--|--|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT<br><b>Mrs Olga Smith</b> |  | ADDRESS<br><b>8075 Old Montgomery Rd 21043</b> |  |
|--|--|--------------------------|--|--|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>2049</b> IMMEDIATE CAUSE (a) <b>intracerebral hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>acute non lymphocytic leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|---|--|---|--|

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |
|---|--|--|--|

|                                       |  |  |  |   |  |   |  |
|---------------------------------------|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION<br><b>NONE</b> |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|---------------------------------------|--|--|--|---|--|---|--|

|   |  |  |  |  |  |                                 |  |
|---|--|--|--|--|--|---------------------------------|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>N/A</b> 19 <b>82</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>N/A</b> |  |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b> |  | 21f. LOCATION<br>STREET<br><b>N/A</b>  |  | CITY OR TOWN<br>COUNTY<br>STATE |  |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 22a. certify that (I) (this hospital) attended the deceased from <b>AUG 6</b> , 19 <b>82</b> , to <b>AUG 10</b> , 19 <b>82</b> that (I) (we) lost<br>saw the deceased alive on <b>AUG 9</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|

|   |  |  |  |                     |  |                                    |  |
|---|--|--|--|---------------------|--|------------------------------------|--|
| 22b. SIGNATURE<br><b>St Michael Hamilton MD</b> |  |  |  | DEGREE<br><b>MD</b> |  | 22c. DATE SIGNED<br><b>8/10/82</b> |  |
|---|--|--|--|---------------------|--|------------------------------------|--|

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. MICHAEL HAMILTON</b> |  |  |  | 22c. ADDRESS<br><b>UNIV. OF MD HOSP, BALT MD</b> |  |  |  |
|---|--|--|--|--|--|--|--|

|  |  |                                  |  |  |  |  |  |
|--|--|----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(1) <b>Burial</b> |  | 23b. DATE<br><b>Aug 13, 1982</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b> |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Howard, Maryland</b> |  |
|--|--|----------------------------------|--|--|--|--|--|

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br><b>Harry HWitzke 4112 Columbia Rd</b> |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 11 1982</b> |  | REGISTRAR'S SIGNATURE<br><b>John J. Carr</b> |  |
|---|--|--|--|---|--|--|--|

U.S.A.

Howard

John H. Smith Co.

John H. Smith Co.

John H. Smith Co.

U.S.A.

Howard

Howard

Aug 19, 1902

Howard

John H. Smith Co.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 9 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES E. SMITH</b>                    |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 3, 1982</b> |   |  | 2b. HOUR<br><b>11:05p</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 25, 1916</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Aircraft Mfrg.</b>                        |  |  |  |   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>814 W. 35th Street</b>                                  |  |  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles E. Smith</b>                 |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cora M. Hedrick</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212 10 2560</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Lillian E. Smith same</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Peritonitis**

5715  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Ascites**

DUE TO, OR AS A CONSEQUENCE OF

(c) **End stage carcinoma**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

**Renal failure, hyperkalemia**

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/2</b> , 19 <b>82</b> , to <b>8/3</b> , 19 <b>82</b> , that (I) (we) last<br>saw the deceased alive on <b>8/3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Drew Pardoll</b>   |  | DEGREE<br><b>MD PhD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Drew Pardoll</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |  |   |  |

|  |  |                            |  |  |  |  |  |
|--|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>            |  | 23b. DATE<br><b>8/7/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Shrewsbury Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Shrewsbury York Co. Pa.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Burgee Funeral Home 3631 Falls Road 21211</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG - 6 1982</b>             |  |  |  |

Copyright Clearance Center

15. York Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |   |                                   |  |
|--|--|--|--|---|--|--|---|-----------------------------------|--|
| 1- STATE REGISTRAR   |  |  |  |   |  |  |   |                                   |  |
| REG. NO. 8 2 2 0 8 9 4   |  |  |  |   |  |  |   |                                   |  |
| 1 DECEASED NAME (TYPE OR PRINT) Edith SMITH BB.  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 8 16 82   |  | 2b. HOUR 11:10 M  |                                   |  |
| 3 SEX n  |  | 4 RACE B   |  | 5. DATE OF BIRTH MONTH DAY YEAR 8 15 82   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS  |   | IF UNDER 1 YEAR MONTHS DAYS       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  |   |                                   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSP |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |                                   |  |
| 13a. STATE Md.   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN Balto.  |  | 13e. STREET ADDRESS 2308 Southern Ave. 21214   |   |                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |   |                                   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7702 CARDIAC ARREST  |  |  |  |   |  |  |   |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMOTHORAX X.3  |  |  |  |   |  |  |   |                                   |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Prematurity  |  |  |  |   |  |  |   |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/16 19 82 to 8/16 19 82, that (I) (we) last saw the deceased alive on 8/16 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |                                   |  |
| 22b. SIGNATURE B. Smaus  |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |   |                                   |  |
| 24. FUNERAL DIRECTOR NAME Baltimore City Hospitals   |  |  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 14 1982 John J. Cahill  |   |                                   |  |



6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 8 9 5

REG. NO.

|  |  |       |  |       |                                      |   |                     |     |                      |          |  |
|--|--|-------|--|-------|--------------------------------------|---|---------------------|-----|----------------------|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST | MIDDLE   | LAST  | 2a. DATE OF DEATH                    |   | MONTH               | DAY | YEAR                 | 2b. HOUR |  |
| 1-Mortense   |  |       |  | Smith | Aug                                  |   | 13                  | -   | 82                   | 6:55 PM  |  |
| 3. SEX   | 4. RACE  |       | 5. DATE OF BIRTH   |       | 6. AGE (IN YEARS LAST BIRTHDAY)      |   | IF UNDER 1 YEAR     |     | IF UNDER 24 HRS      |          |  |
| Female   | Black  |       | 5 MONTH 25 YEAR 1919   |       | 63 YRS                               |   | MONTHS DAYS         |     | HOURS MIN.           |          |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |       | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                     |     |                      |          |  |
| Maryland   | U. S. A.   |       |  |       | Baltimore City MD.                   |   |                     |     |                      |          |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |       | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |       | 12b. KIND OF BUSINESS OR INDUSTRY    |   |                     |     |                      |          |  |
| Baltimore  | Provident Hospital   |       | Saleslady  |       | Hecht Co.                            |   |                     |     |                      |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. COUNTY  |       | 13c. CITY OR TOWN  |       | 13d. INSIDE CITY LIMITS?             |   | 13e. STREET ADDRESS |     | 2401 St. Stephens Ct |          |  |
| Maryland   | Baltimore  |       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |       | Balto., Maryland                     |   | 21216               |     |                      |          |  |
| 14. FATHER'S NAME  |  |       | 15. MOTHER'S MAIDEN NAME   |       |                                      |   |                     |     |                      |          |  |
| Charles Smith  |  |       | Gertrude Blackstone  |       |                                      |   |                     |     |                      |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)                             |  |       | 16b. SOCIAL SECURITY NO.   |       |                                      | 17. INFORMANT   |                     |     |                      |          |  |
| No   |  |       | 214-22-0448  |       |                                      | Baltimore, Md. 21216<br>Mrs. Barbara Greene 2853 Elgin Avenue |                     |     |                      |          |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Melanotic Breas Cancer to

1749

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

Porain.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-2-82 to 8-13-82, that (we) last saw the deceased alive on 8-13-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>H. Sevadoss  |  |  |  | DEGREE<br>MD.  |  | 22c. DATE SIGNED<br>8/13/82                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. Sevadoss   |  |  |  | 22e. ADDRESS<br>Provident Hospital.  |  |  |  |

|   |                      |   |  |
|---|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial | 23b. DATE<br>8/19/82 | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park | 23d. LOCATION<br>BALTIMORE County, Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Herbert E. Nutter   |                      | ADDRESS<br>BALTIMORE 3035 W. NORTH AVE.                 | 25a. DATE REC'D. BY REGISTRAR<br>AUG 17 1982 |
|   |                      | 25b. REGISTRAR'S SIGNATURE<br>John J. Canick            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |                                    |  |  |   |   | 8   | 2               | 2                 | 0                                 | 8  | 9 | 6                   |  |
|---|--|--|--|--|------------------------------------|--|--|---|---|---|-----------------|-------------------|-----------------------------------|--|---|---------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |                                    |  |  |   |   | CERTIFICATE OF DEATH  |                 |                   |                                   |  |   |                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  |                                    |  |  |   |   | 2a. DATE OF DEATH   |                 |                   |                                   |  |   |                     |  |
| JAMES Smith   |  |  |  |  |                                    |  |  |   |   | 8 8 82 2:30 PM  |                 |                   |                                   |  |   |                     |  |
| 3. SEX  |  |  | 4. RACE  |  | 5. DATE OF BIRTH                   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)         |   |   | IF UNDER 1 YEAR |                   | IF UNDER 2 HRS                    |  |   |                     |  |
| male  |  |  | Black  |  | 08 18 1909                         |  |  | 72 YRS                                  |   |   | MONTHS          |                   | DAYS                              |  |   |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |                 |                   |                                   |  |   |                     |  |
| N.C.  |  |  | USA  |  |                                    |  |  |   | Baltimore City MD.  |   |                 |                   |                                   |  |   |                     |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |  |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                 |                   | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |                     |  |
| Baltimore   |  |  | Greater Penn. Nursing Home   |  |                                    |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| 13a. STATE  |  |  |  |  |                                    |  |  |   |   | 13b. COUNTY   |                 | 13c. CITY OR TOWN |                                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS |  |
| MD  |  |  |  |  |                                    |  |  |   |   |   |                 | Baltimore         |                                   | YES  |   | 1300 E. Lanvale St. |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME           |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| Abraham Smith   |  |  |  |  | Harriett Davis                     |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO.           |  |  |   |   | 17. INFORMANT ADDRESS   |                 |                   |                                   |  |   |                     |  |
| No  |  |  |  |  | 245-20-3226                        |  |  |   |   | Leonie Smith 1300 E. Lanvale St.                              |                 |                   |                                   |  |   |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |                                    |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |                 |                   |                                   |  |   |                     |  |
| PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) Cancer of the Lung   |  |  |  |  |                                    |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |  |                                    |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |                                    |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |                                    |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |                                    |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                 |                   |                                   |  |   |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
|   |  |  | P.M. 19  |  |                                    |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |                 |                   |                                   |  |   |                     |  |
|   |  |  |  |  |                                    |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 17-2 19 82, to 8-8 19 82, that (I) (we) lost (a) the deceased alive on 8-8 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (did not) view the body after death. |  |  |  |  |                                    |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| 22b. SIGNATURE DEGREE   |  |  |  |  |                                    |  |  |   |   | 22c. DATE SIGNED  |                 |                   |                                   |  |   |                     |  |
| Reginald O. CROSLLEY MD   |  |  |  |  |                                    |  |  |   |   |   |                 |                   |                                   |  |   |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |                                    |  |  |   |   | 22e. ADDRESS  |                 |                   |                                   |  |   |                     |  |
| Reginald O. CROSLLEY MD   |  |  |  |  |                                    |  |  |   |   | 1235 E. Monument St Balto                                     |                 |                   |                                   |  |   |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |   |   |                 |                   |                                   |  |   |                     |  |
| Burial  |  |  | 8/13/82  |  | Cedar Hill Cem.                    |  |  | Baltimore Co. MD                        |   |   |                 |                   |                                   |  |   |                     |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  |                                    |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE           |                 |                   |                                   |  |   |                     |  |
| Wm. C. March F/H 1101 E. North Ave.   |  |  |  |  |                                    |  |  |   |   | AUG 11 1982 John J. Connel                                    |                 |                   |                                   |  |   |                     |  |



12/10/1900  
MAY 1901  
JUN 1901  
JUL 1901  
AUG 1901  
SEP 1901  
OCT 1901  
NOV 1901  
DEC 1901

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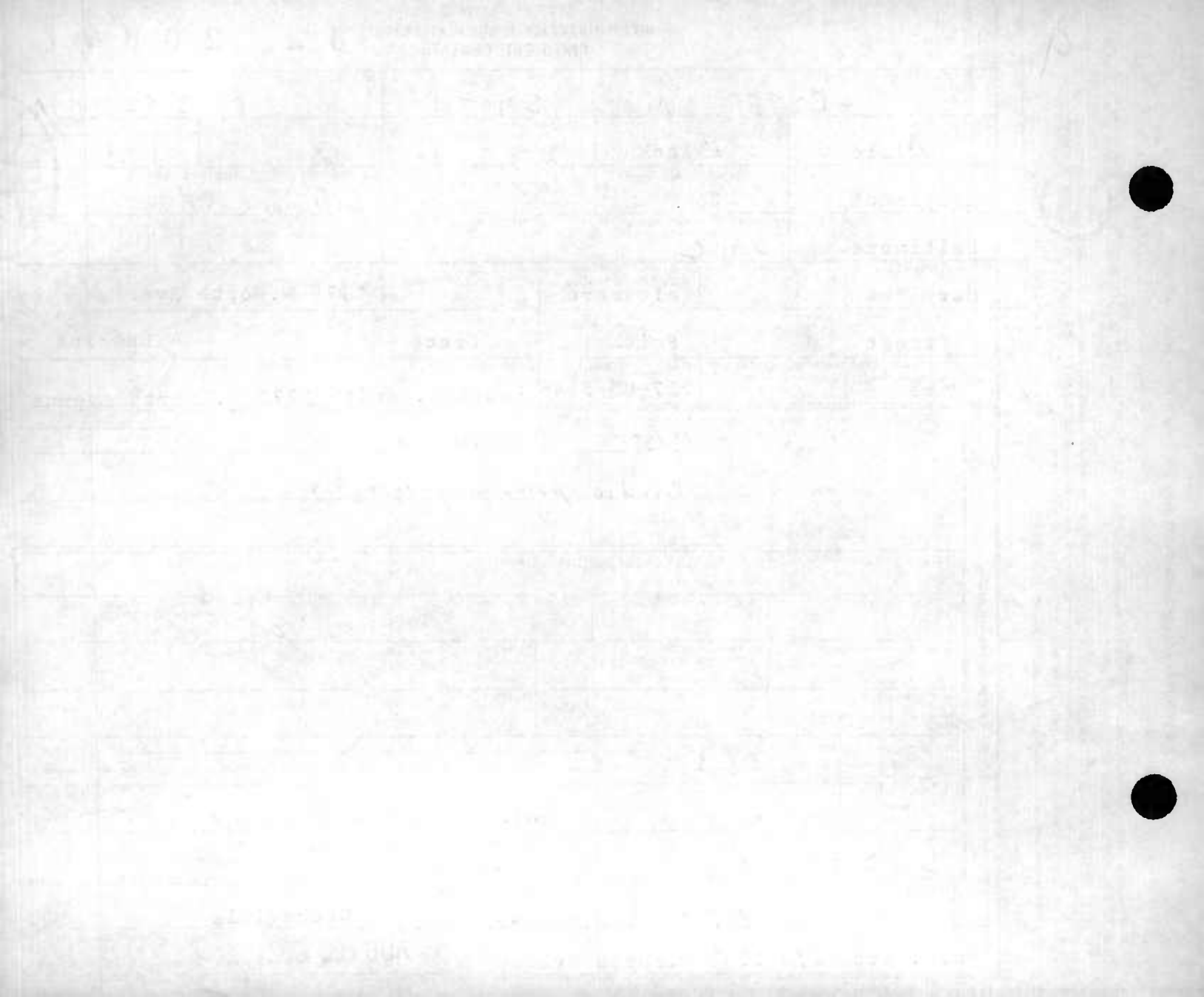
1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 2 2 0 8 9 7<br>REG. NO.  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST<br>L E S T E R   |  | MIDDLE<br>M  |  | LAST<br>S M I T H   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 3 8 2  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 2 14  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  | 7b. HOUR<br>9:10 AM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UMCC |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2772 W. North Ave   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ernest Smith  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Grace Hawkins  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>217-03-5646  |  | 17. INFORMANT ADDRESS<br>Leona M. Smith 2772 W. North Avenue   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>gastric Carcinoma</u><br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Cardio pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/3, 1982, to 8/3, 1982, that (I) (we) last saw the deceased alive on 8/3, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>L. Sigman  |  |  |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. SIGMAN   |  |  |  | 22e. ADDRESS<br>UMCC   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>8/9/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Crownville MD.                                       |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 E. North Avenue   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 06 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |  |                                   | 8 2 2 0 8 9 8                                |  |
|---|--|--|--|---|--|--|---|--|-----------------------------------|--|--|
| 1- FOR STATE REGISTRAR  |  |  | REG. NO.   |   |  |  |   |  |                                   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  | 2a DATE OF DEATH                                 |   |  | MONTH DAY YEAR   |   |  | 2b HOUR                           |  |  |
| LOUISE JANE SMITH   |  |  | 8 21 82  |   |  | 7:10 P.M.  |   |  |                                   |  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.                             |  |
| FEMALE  |  | WHITE  |  | 7 19 83   |  | 99 YRS.  |   | MONTHS DAYS  |                                   | HOURS MIN.                                   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  |                                   |  |  |
| W. VIRGINIA   |  | USA  |  |   |  | Baltimore City MD.   |   |  |                                   |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| BALTIMORE   |  | EDGEWOOD NURSING HOME  |  |   |  | SCHOOL TEACHER   |   |  | EDUCATION                         |  |  |
| 13a. STATE  |  |  | 13b. COUNTY                                      |   | 13c. CITY OR TOWN                            |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS               |  |  |
| Md.   |  |  | Balt. City                                       |   | BALT.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6000 Ballona Ave. N.W.            |  |  |
| 14 FATHER'S NAME  |  |  | 15 MOTHER'S MAIDEN NAME                          |   |  |  |   |  |                                   |  |  |
| ARTHUR ZORMAN SMITH   |  |  | ANNA GORDON                                      |   |  |  |   |  |                                   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b SOCIAL SECURITY NO.                          |   | 17 INFORMANT ADDRESS                         |  |   |  |                                   |  |  |
|   |  |  | 519-60-0316T                                     |   | ERIC S. RUARIK 1505 CLEARWOOD RD BALTO 21234 |  |   |  |                                   |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)   |  |  |  |   |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |   |  |                                   |  |  |
| IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE   |  |  |  |   |  |  |   |  |                                   | 20 yrs                                       |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |   |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |  |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |   |  |                                   |  |  |
| 19a DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |   |  | 20a AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |                                   |  |  |
|   |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY                              |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |                                   |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR                         |   |  |  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY                             |   |  | 21f. LOCATION  |   |  |                                   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |   |  | STREET CITY OR TOWN COUNTY STATE   |   |  |                                   |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from 2-27 1979 to 8-21 1982, that (I) (we) last saw the deceased alive on 8-20 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |   |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE  |  |  |  |   |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED                             |  |
| FREDERICK J. VOLLMER MD.  |  |  |  |   |  |  |   |  |                                   | 8-21-82                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |  | 22e. ADDRESS   |   |  |                                   |  |  |
| FREDERICK J. VOLLMER, MD  |  |  |  |   |  | 6100 YORK RD BALTIMORE MD 21212  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY           |  |   | 23d. LOCATION  |                                   |  |  |
| Burial  |  |  | 8/24/82  |   | Ft. Lincoln Cem.                             |  |   | Brentwood, Md.   |                                   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |  |  |
| Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.   |  |  |  |   |  | AUG 25 1982  |   | John J. Gawler   |                                   |  |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 8220899   |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Magdalene C. Smith</i>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <i>8/1/82</i> |  |  | 2b. HOUR <i>1:15 A.M.</i>   |  |
| 3. SEX <i>F</i>   |  | 4. RACE <i>W</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <i>12-4-15</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>66</i> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Canada</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH <i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hospital</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <i>md.</i>   |  | 13b. COUNTY <i>city</i>  |  | 13c. CITY OR TOWN <i>Baltimore</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <i>4233 Old Frederick Rd.</i>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>James</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rose Salkowski</i>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>   |  | 16b. SOCIAL SECURITY NO. <i>218-03-4175</i>  |  | 17. INFORMANT <i>Mr. Harry Smith</i>  |  | ADDRESS <i>4233 Old Frederick Rd. Balto., Md.</i>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO-PULMONARY ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>RENAL FAILURE, HEPATITIS, GI BLEEDING</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>BRONCHOGENIC CARCINOMA</i>                    |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i><br><i>15 mths</i>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE <i>Philip M Lam</i>  |  |  |  | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED <i>08-1-82</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PHILIP M LAM</i>   |  |  |  | 22e. ADDRESS <i>ST. AGNES HOSPITAL, BALTIMORE, MD</i>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>  |  | 23b. DATE <i>8/1/82</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i> ADDRESS <i>Balto., Md.</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>AUG 4 1982</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Thomas J. Nathan</i>   |  |   |  |

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NOTICE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 0 9 0 0<br>REG. NO.   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |   |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>MARIAN E. SMITH   |  |   |  | 2b. HOUR<br>10 <sup>50</sup> A.M.   |  |  |   |
| 3. SEX<br>F   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 2 24   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MISSOURI   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. MD. HOSP. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE MD 13c. CITY OR TOWN ELICOTT CITY  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3449 NANMARK CT. 21043  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>late Raymond Schiefelbusch   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nida Stewart  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO.<br>487-28-0490   |  | 17. INFORMANT ADDRESS<br>Ronald D. Smith 3449 Nanmark Ct Ellicott City  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>1749 IMMEDIATE CAUSE (a) metastatic Breast Cancer<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>June 1987 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (1) (this hospital) attended the deceased from 8/4 19 82, to 8/20 19 82, that (1) we last saw the deceased alive on 8/20/82 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (1) did not view the body after death. |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br>Michael R. Kessler MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>8/24/82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL R. KESSLER MD  |  |   |  | 22e. ADDRESS<br>UNIV of MD. Hospital  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Aug. 25, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill  |  | 23d. LOCATION<br>Blythedale, Missouri STATE  |   |
| 24. FUNERAL DIRECTOR<br>Harry H Witzke 4112 Columbia Rd. Ellicott City  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 24 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |   |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial/transit permit. Then please remove conforming papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 0 1

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Perry Elmer Smith   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>August 18, 1982   |  | 2b. HOUR<br>17:15 M  |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 7 14   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Missouri  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |   | 12a. USUAL OCCUPATION (Ret.)<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sheet Metal Worker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Westinghouse  |
| 13a. STATE<br>MD.  | 13b. COUNTY<br>Howard   | 13c. CITY OR TOWN<br>Hanover  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>Box-187 Smith's Lane  |  |
| 14. FATHER'S NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>John W. Smith  |   | 15. MOTHER'S MAIDEN NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Unknown  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>W.W. 11   | 17. INFORMANT<br>ADDRESS Same as # 13<br>Son - Mr. Stephen V. Smith, Sr.                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4289 IMMEDIATE CAUSE (a) Cardiac Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Severe Cardiac disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Nodal disease<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1973 |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Congestive Heart Failure   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-6, 1982, to 8-13, 1982, that (I) (we) last saw the deceased alive on 8-13, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br>DR. LAWRENCE I. SILVERBERG   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>8-19-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. LAWRENCE I. SILVERBERG  |   | 22e. ADDRESS<br>9350 BALTIMORE NAT'L PIKE, C.C., MD. 21043  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>24 Aug. 82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mountain View Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Kingman, Mohave, Arizona               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Easter<br>Singleton Funeral Home  |   | ADDRESS<br>Glen Burnie<br>Maryland  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 20 1982   | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |

MEDICAL CERTIFICATION

175-1  
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175-1  
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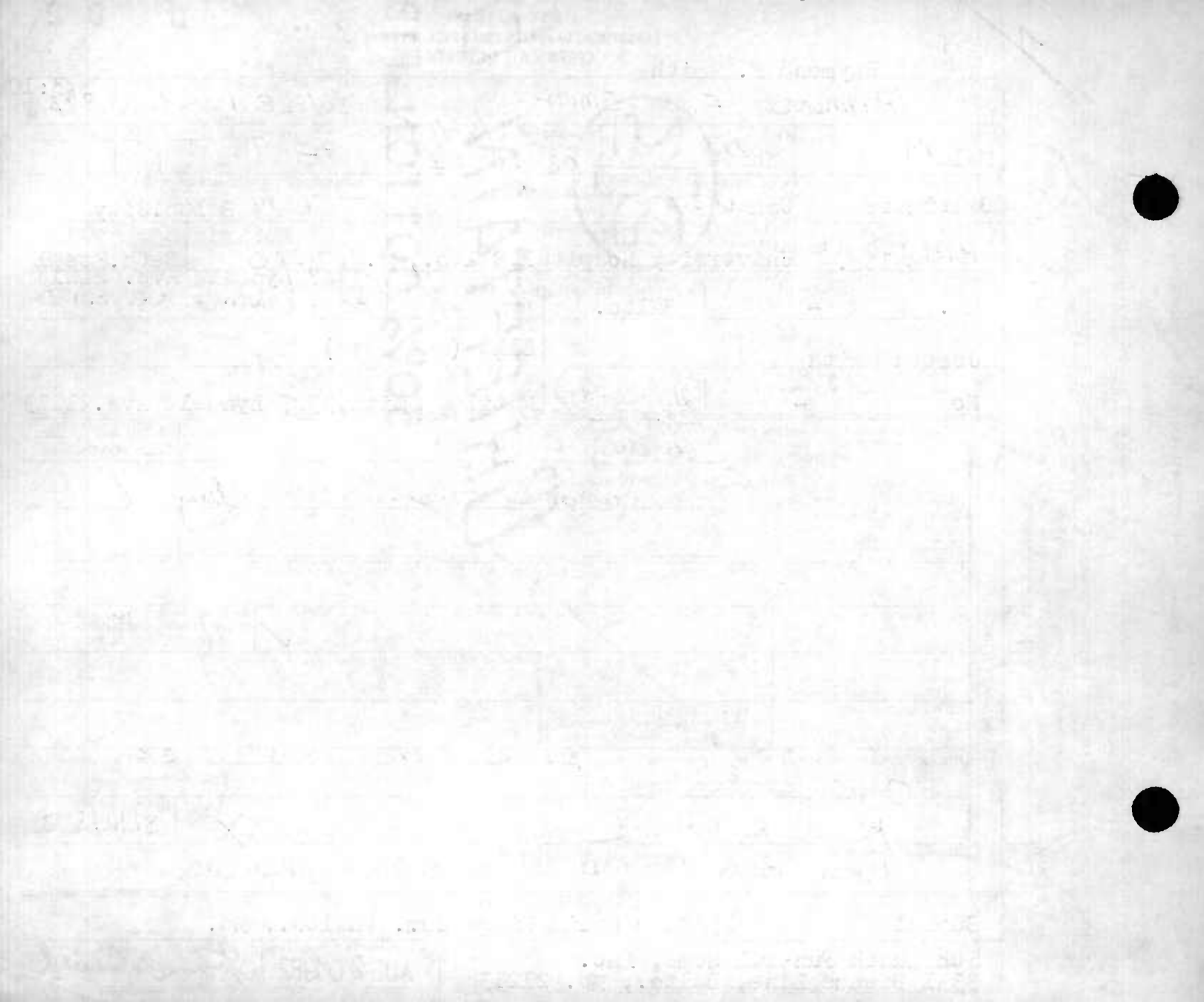
175-1  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR <b>Raymond F. Smith</b>   |  |  |  |  | REG. NO.   |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>RAYMOND F. SMITH</b>   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>8/16/82 16 82</b>  |   |  | 2b. HOUR:10 31 P M  |  |
| 3. SEX <b>Male M</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>8/26/03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78 78</b>                                      |  | IF UNDER 1 YEAR IF UNDER 24 HRS.  |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY Balto. City</b>                      |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO. Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital, Bal o., Md.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Beth Steel</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>-</b>   |  | 13c. CITY OR TOWN <b>Balto.</b>  |  | 13e. STREET ADDRESS <b>3327 Lyndale Ave. 21213</b>                                |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Smith</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella (hee Ware)</b>                            |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>215-05-9617</b>  |   |  |   |  |
| 17. INFORMANT ADDRESS <b>Matilda Smith, 3327 Lyndale Ave. 21213</b>  |  |  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardio pulmonary arrest</b>  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic squamous cell Carcinoma</b>   |  |  |  |  |  |   |  |   |  |
| (c)  |  |  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19               |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/8/82</b> , 19 <b>82</b> , to <b>8/16</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Ronan B. Wills MD</b>  |  |  |  |  | DEGREE   |   |  | 22c. DATE SIGNED <b>8/16/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronan B. Wills MD</b>   |  |  |  |  | 22e. ADDRESS <b>22 So. Greene St, Balto, MD</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  | 23b. DATE <b>8/19/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>                                   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b> |   |  |
| 24. FUNERAL DIRECTOR <b>Schamunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 20 1982</b>                                  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 2 0 9 0 3  |  |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME  |  |  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR   |  |
| TRISHA L. SMITH   |  |  |  | AUGUST 20, 1982  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |
| Female  |  | Caucasian  |  | MONTH DAY YEAR   |  |
|   |  |  |  | October 29, 1976   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Indiana   |  | U.S.A.   |  | 5 YRS.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL   |  | BALTIMORE CITY MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| N/A   |  | N/A  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Pennsylvania  |  | Lehigh   |  | Macungie   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |  |  |
| Ronald L. Smith   |  | Wendy L. Smith   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| N/A   |  | None   |  | Ronald L. Smith, 50 Gehman Road  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 2040 IMMEDIATE CAUSE (a) cardiac arrhythmias  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) sepsis   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |
| acute lymphocytic leukemia  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
| -   |  | -  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |  |
|   |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19, 1982, to 8/20, 1982, that (I) (we) lost saw the deceased alive on 8/20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| S. Brouwer MD   |  |  |  | 8/20/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |
| S. Brouwer M.D.   |  | Johns Hopkins Hosp. Baltimore, Md.   |  | 2/20/5   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | 8/24/82  |  | Fairview Cemetery  |  |
| 24. FUNERAL DIRECTOR  |  | 24b. NAME OF CEMETERY OR CREMATORY   |  | 24c. LOCATION CITY OR TOWN COUNTY STATE  |  |
| John E. Fisher  |  | Fairview Cemetery  |  | Macungie, Lehigh Co., Pa.  |  |
| 24a. DATE REC'D. BY REGISTRAR   |  | 24b. REGISTRAR'S SIGNATURE   |  |  |  |
| AUG 30 1982   |  | John J. Carick   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

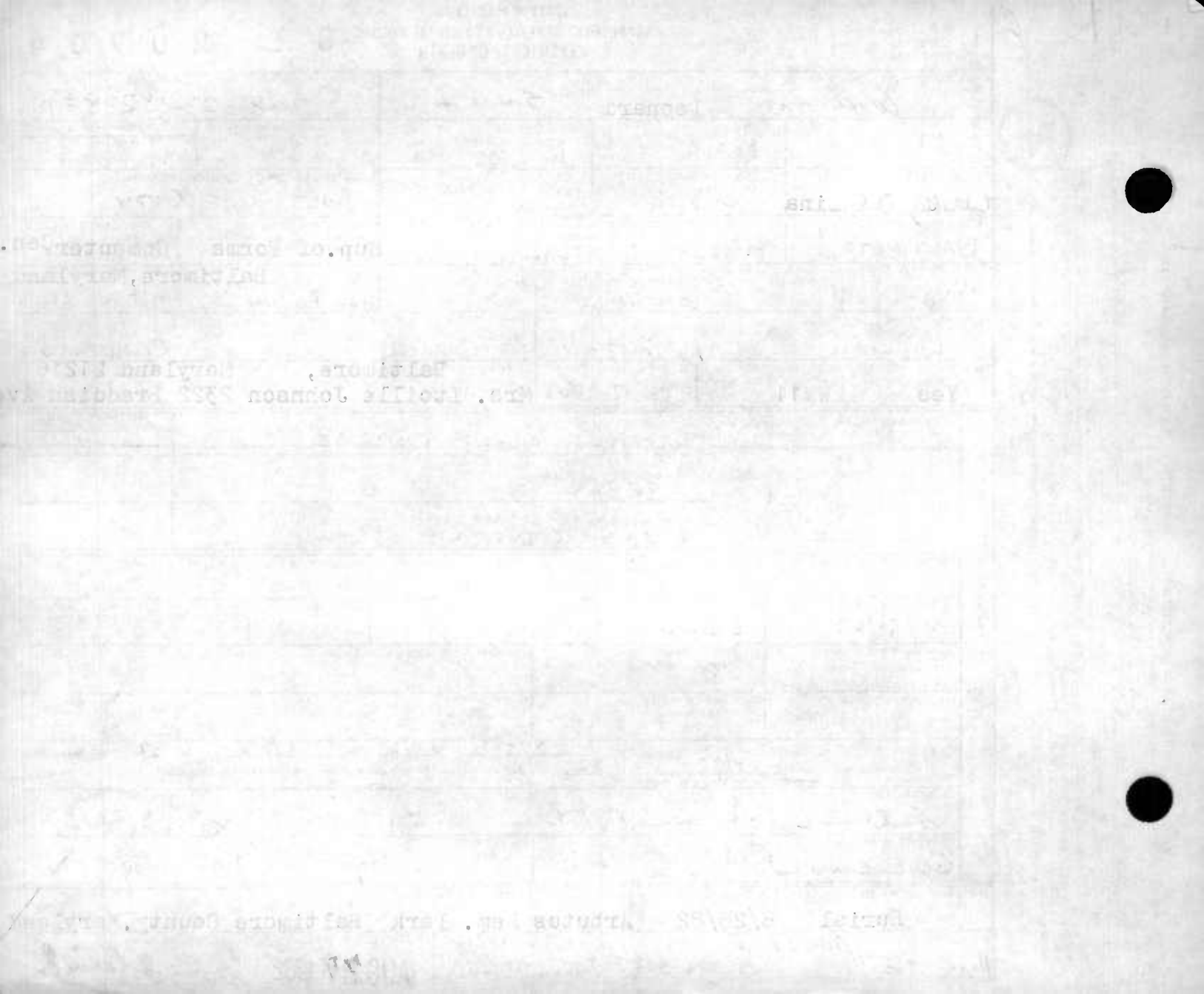
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a necropsy performed.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 0 4  
REG. NO.

|   |                        |  |  |   |  |
|---|------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM Leonard SMITH</b>  |                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-23-82</b>  |  | 2b. HOUR<br><b>8:23 P M</b>   |  |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>BLACK</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 02 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |  |   |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE<br><b>MD</b>   |                        | 12b. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 12c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM SMITH</b>  |                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE CRAWFORD</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW11</b>   |  | 17. INFORMANT<br><b>Baltimore, Maryland 21216</b><br><b>Mrs. Lucille Johnson 2322 Braddish Av</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629 MULTIPLE ORGAN FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>LUNG CANCER</b>  |                        |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |                        |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>8/5/82</b>   |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>LUNG CANCER</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/5</b> , 19 <b>82</b> , to <b>8/23</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/23</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                        |  |  |   |  |
| 22b. SIGNATURE<br><b>Guillermo W. Arnaud MD</b>   |                        | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>8/23/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GUILLERMO W. ARNAUD MD</b>  |                        | 22e. ADDRESS<br><b>MERCY HOSPITAL, BALTIMORE, MD.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                        | 23b. DATE<br><b>8/28/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Maryland</b>   |                        | 23e. DATE REC'D. BY REGISTRAR<br><b>AUG 28 1982</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HERBERT E. NATION</b>  |                        | 24b. ADDRESS<br><b>3085 W. NORTH AVE.</b>  |  | 24c. REGISTRAR'S SIGNATURE<br><b>John J. Casper</b>   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 0 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |   |   |   |  |
|--|--|--|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DOROTHY SNYDER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 11, 1982</b>          |   |  | 2b. HOUR<br><b>09:10AM</b>   |   |   |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 15 29</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53 YRS.</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CASHIER</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DRUG FAIR, INC.</b>   |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTO. HGLDS</b>                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2634 VIRGINIA AVENUE, 21227</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SYLVIO SCHIAZZA</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>THERESA DICOCO</b> |   |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>288-26-6670</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>LORAIN R. SNYDER 2634 VIRGINIA AVENUE</b>       |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1830 IMMEDIATE CAUSE (a)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>b) <b>Rivarian Ca. metastatic stage IV</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a)<br><b>Intestinal obstruction</b> |  |  |  |   |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH           |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/8</b> , 19 <b>82</b> to <b>8/11</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/11</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>DORA MAMODESENA</b>   |  |  | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8/11/82</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DORA MAMODESENA</b>  |  |  | 22e. ADDRESS<br><b>544 Bal MD</b>                                      |   |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>08-13-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PARK</b>             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKBRIDGE HOWARD MARYLAND</b>                  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>                                    |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>AUG 13 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |   |  |

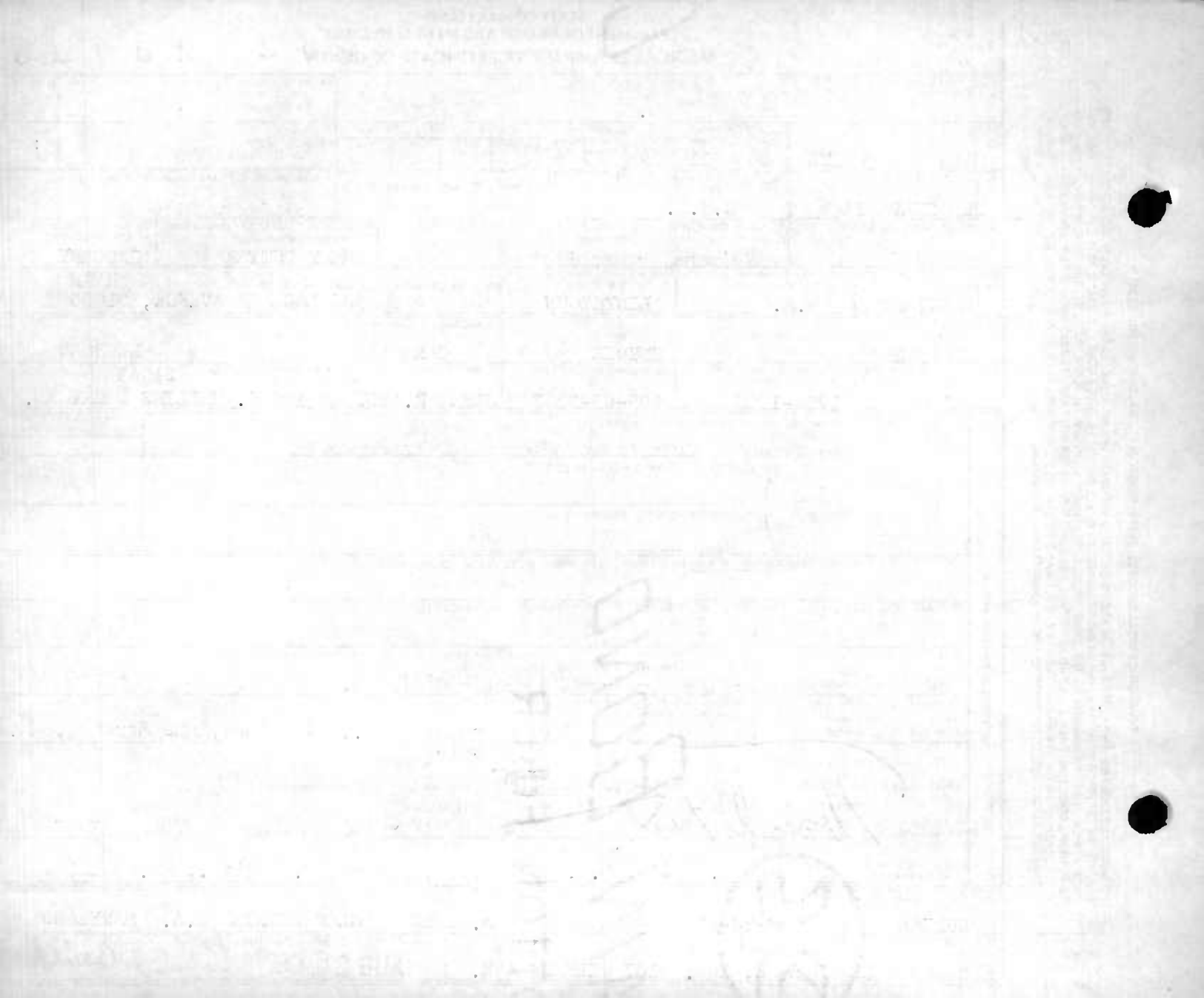
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |  |  |  |  |  |  | REG. NO. 20906  |  |
|---|--|------------------|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |                  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>RUSSELL H. SNYDER   |  |                  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR<br>8 25 19 82 |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>06 11 05  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>77                     |  | 7. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  | 2b. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>8 25 19 82   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MEAT CUTTER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>GROCERY  |  |
| 13a. STATE<br>MARYLAND  |  |                  |  | 13b. COUNTY<br>A.A.  |  | 13c. CITY OR TOWN<br>LINTHICUM                                 |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>506 LACLAIR AVENUE, 21090  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>HARVEY SNYDER  |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CARMELLA LEOBOLD |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>YES   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>1924-1926  |  | 17. INFORMANT<br>GLEN BURNIE                                   |  | ADDRESS<br>21061 JAMES R. SNYDER 100 S. HOLLINS FERRY RD.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9550 IMMEDIATE CAUSE (a) <u>Gunshot wound of head (handgun)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |                  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>8:44 P.M. 8-24-1982   |  |                  |  | 21b. TIME OF INJURY HOUR MONTH DAY YEAR<br>8:44 P.M. 8-24-1982   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Self-inflicted.   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>506 Leclare Ave., Linthicum, Anne Arundel, Md.   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |  |                  |  | TITLE (SPECIFY)<br>Deputy Chief  |  |  |  | DATE SIGNED<br>8-26-82   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |                  |  | ADDRESS<br>111 Penn St., Balto., Md. 21201   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |                  |  | 23b. DATE<br>08-28-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GLEN HAVEN MEM. PARK     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>GLEN BURNIE A.A. MARYLAND   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME, INC.   |  |                  |  | ADDRESS<br>4107 WILKENS AVE.   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 26 1982                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i>   |  |   |  |

BP \_\_\_\_\_





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |   |  |  |  |   | REG. NO. 20907   |  |
|--|--|----------------------|--|---|---|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |                      |  |   |   |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Jerry R. Sommers</b>   |  |                      |  |   |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> |  | MONTH DAY YEAR <b>8 23 19 82</b>  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>12 23 64</b>                                   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>17 YRS.</b>   |  | 7c. DATE PRONOUNCED DEAD <b>8 23 19 82</b>   |   | 2b. HOUR <b>7:15 A.M.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>         |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital - STU</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Busboy</b>                    |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>                              |  |
| 13a. STATE <b>Maryland</b>   |  |                      | 13b. COUNTY <b>--</b>  |   | 13c. CITY OR TOWN <b>Baltimore</b>                              |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>1329 Cambria Street, 21225</b>                   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Gerry R. Sommers</b>  |  |                      |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marylou Myers</b> |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>220-64-3155</b>                                       |   | 17. INFORMANT ADDRESS <b>Gerry Sommers 1329 Cambria St., 21225</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Multiple Injuries</b><br><b>8151</b> IMMEDIATE CAUSE (a) <b>Multiple Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Multiple Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Multiple Injuries</b>                     |  |                      |  |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |   |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                 |   |  |  |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR <del>XX</del> MONTH DAY YEAR <b>11:25 P.M. 8 15 1982</b> |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>passenger in auto/fixed object impact</b> |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>         |   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Hanover &amp; Potee Sts., Baltimore, Maryland</b>                        |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |   |  |  |  |   |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |                      |  |   |   | TITLE (SPECIFY) <b>M.D. Assistant</b>  |  |  | DATE SIGNED <b>8-23-82</b>  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                      |  |   |   | ADDRESS <b>111 Penn Street</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>08-26-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Mem. Gardens</b>  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marriottsville Howard Md</b> |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>  |  |                      |  |   |   | ADDRESS <b>4107 Wilkens Ave.</b>   |  | 25a. DATE REC'D BY REGISTRAR <b>AUG 25 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>                                  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 0 8

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |  | HOURS MIN.   |  |
| FIRST MIDDLE LAST   |  | 08 25 82   |  | 708 P M  |  |
| 2. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |
| male  |  | Cauc   |  | MONTH DAY YEAR   |  |
| 16. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Maryland  |  | U.S.A.   |  | 03 14 80   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Baltimore   |  | Sinai Hospital   |  | Baltimore City MD  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Ret. Pattern Maker  |  | & Co.  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| 1301 MD   |  | Balto.   |  | Randallstown   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |  |  |
| George W. Speake  |  | Jennett Walker   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |
| yes   |  | 216-07-2945  |  | Miss Mary E. Speake  |  |
|   |  |  |  | ADDRESS 3725 Courtleigh Dr. Randallstown, Md. 21133  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |
| 2028 IMMEDIATE CAUSE (a) Sepsis   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Lymphoma   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
|   |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
|   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/14 19 82 to 8/25 19 82, that (I) (we) last saw the deceased alive on 8/25 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, or (we) did (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Paul Schwartz   |  | M.D.   |  | 8/25/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |
| PAUL Schwartz M.D.  |  | Sinai Hospital Belvedere/Greenspring   |  | 2125   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | 8/28/82  |  | Cedar Hill Cem.  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REG. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Loring Byers Funeral Directors  |  | AUG 26 1982  |  | John J. Connel   |  |
| 8728 Liberty Rd. Randallstown, Md. 21133  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |   |   |  |  | REG. NO. 20909                                      |  |   |  |
|---|--|---|--|--|---|---|---|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | 2a. DATE OF DEATH <u>27</u> <u>August</u> <u>1982</u> |   |   |  |  |   |  | 2b. HOUR <u>4:15P</u> <u>M</u>            |  |
| I. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Josephine</u> <u>Spindler</u>   |  |   |  |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) <u>81</u> YRS       |   |   |  |  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 3. SEX <u>Female</u>  |  | 4. RACE <u>White</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>Sept.</u> <u>23</u> , <u>1900</u>   |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> <u>MD.</u> |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MA</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Maryland General Hospital</u> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Homemaker</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>                         |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 13a. STATE<br><u>MD</u>   |  | 13b. COUNTY<br><u>AA</u>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13c. STREET ADDRESS<br><u>1264 Tyler Avenue</u>  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>John</u> <u>Sliva</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Mary</u> <u>Majcher</u>  |   |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>NO</u> <u>1</u> <u>-</u>               |  |   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><u>026'09'9108</u>  |  |   |  | 17. INFORMANT<br><u>Theresa Gonet</u>  |   |   |   | ADDRESS<br><u>Same as #13</u>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><u>4100</u> IMMEDIATE CAUSE (a) <u>RECENT MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>SYSTEMIC ATHEROSCLEROTIC VASCULAR DISEASE</u>   |  |   |  |  |   |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 26</u> , 19 <u>82</u> , to <u>August 27</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 27</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |  |   |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>M. Smathers</u>  |  |   |  |  |   | DEGREE<br><u>MD</u>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>8/27/1982</u>                |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Mary Smathers, M.D.</u>   |  |   |  |  |   | 22e. ADDRESS<br><u>C/O Maryland General Hospital</u>  |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>Sept 1, 1982</u>                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Sacred Heart</u>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>New Bedford Bristol MA</u>                     |   |  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>John M. Taylor &amp; Sons</u>  |  |   |  |  |   | ADDRESS<br><u>Annapolis Maryland</u>  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>AUG 31 1982</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Joan J. Conish</u> |  |   |  |

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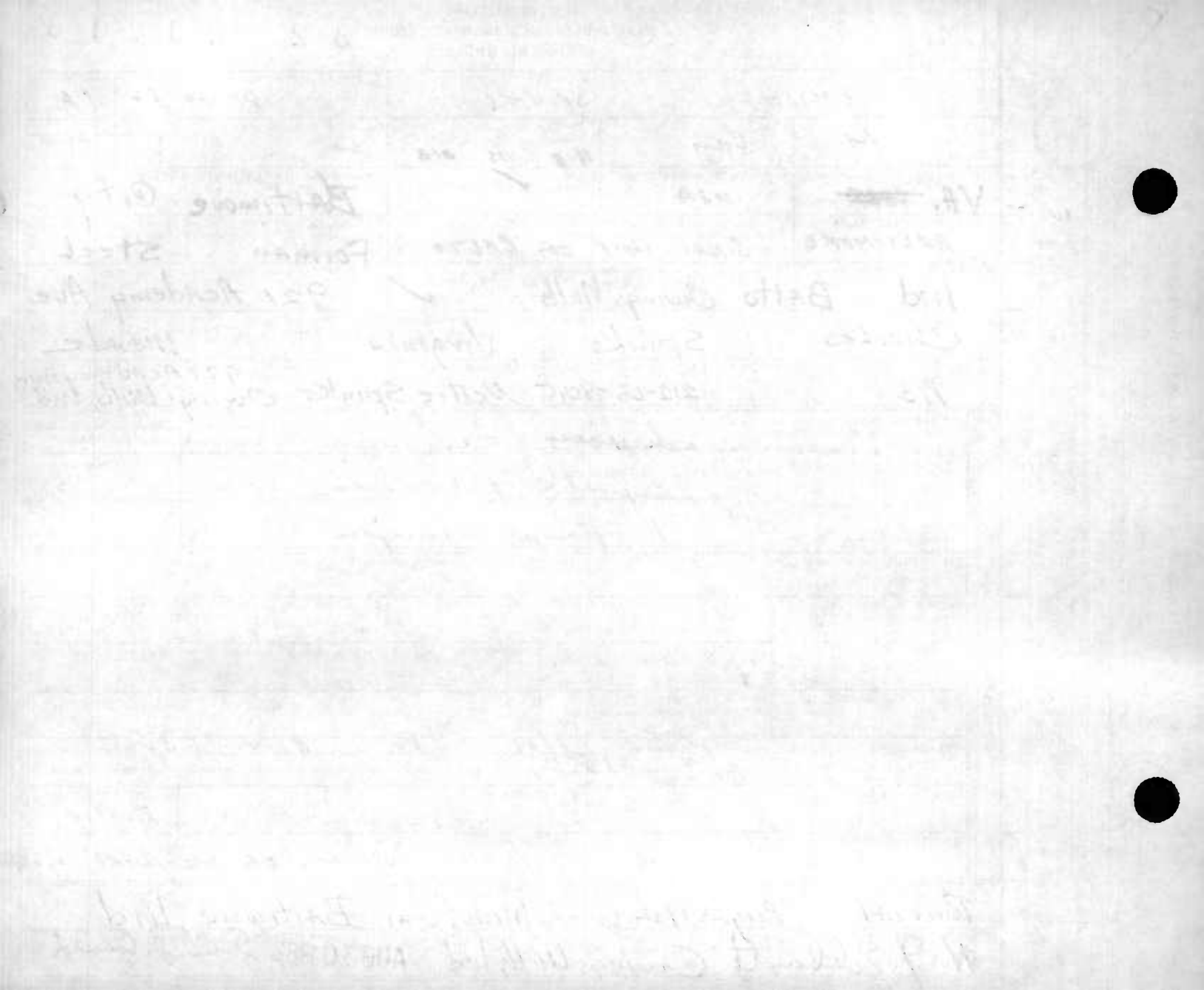
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed - within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| FOR<br>1 - STATE REGISTRAR   |  | REG. NO. 8 2 2 0 9 1 0   |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BALISE SPINKS   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 24 82                              |  |  |  |   |  |
| 3. SEX<br>M  |  | 4. RACE<br>Can   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 03 013   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                  |  | 7b. HOUR<br>1A M   |  | 7a. MONTH DAY YEAR  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>VA. <del>USA</del>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSP. OF BALTO. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel |   |  |
| 13a. STATE<br>md   |  |  |  |   |  | 13b. COUNTY<br>Balto  |  | 13c. CITY OR TOWN<br>Bwings Mills  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>Charles Spinks  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Virginia Meade                                  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>212-03-8045  |  | 17. INFORMANT<br>ADDRESS 921 Academy Ave.<br>Nettie Spinks Owings Mills Md.   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>3200 IMMEDIATE CAUSE (a) <u>Myocardial</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>aspiration pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>H. influenzae meningitis</u> |  |  |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>0 P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/24 19 82 to 8/24 19 82, that (I) (we) lost<br>saw the deceased alive on 8/24 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Jm   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>8/24/82  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E. Lim  |  |  |  | 22e. ADDRESS<br>SINAI HOSPITAL OF BALTIMORE, 2120   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>Aug. 28, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Cem                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md                           |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>H. J. Edelhardt  |  |  |  | ADDRESS<br>Owings Mills Md  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 30 1982   |  |   |  |
|  |  |  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 is marked, the medical examiner must be notified.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 1 1

REG. NO.

|   |   |  |  |  |  |  |  |   |
|---|---|--|--|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |   |
| JOSEPH A. SPRINGER  |   |  | 8-8-82   |  |  | 9:55 AM  |  |   |
| 3 SEX   | 4 RACE  | 5. DATE OF BIRTH   | 6 AGE (IN YEARS LAST BIRTHDAY)                                   |  |  | IF UNDER 1 YEAR  |  |   |
| Male  | White   | 8 29 15  | 66   |  |  | MONTHS DAYS HOURS MIN.   |  |   |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                              |  |  |  |  |   |
| Maryland  | U.S.A.  |  | CITY   |  |  |  |  |   |
| 11. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |   |
| Baltimore   | UNIV OF MARYLAND  |  | President  |  |  | Liquors Inc.   |  |   |
| 13a. STATE  | 13b. CITY OR TOWN   | 13c. INSIDE CITY LIMITS?   | 13d. STREET ADDRESS  |  |  | 13e. ZIP CODE  |  |   |
| Maryland  | Queens Annes Co.  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | Rt. 1 Box 248A   |  |  | 21617  |  |   |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |   |
| First Middle Last   | First Middle Last   |  |  |  |  |  |  |   |
| Louis R. Springer   | Lena Adams  |  |  |  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   | 17. INFORMANT ADDRESS  |  |  |  |  |  |   |
| YES   | WW II   | 212-10-7598 Susan C. Springer Rt.1 Box 248A 21617  |  |  |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aortic Aneurysm</u><br>4413<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>you</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Renal Cell Carcinoma metastatic to Liver.</u>  |   |  |  |  |  |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |
| 7-15-82   |   | Renal Carcinoma  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-6</u> , 19 <u>82</u> , to <u>8-8</u> , 19 <u>82</u> that (I) (we) first saw the deceased alive on <u>7-6</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |  |  |  |  |  |  |   |
| 22b. SIGNATURE  |   | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |   |
| <u>Michael R. Kessler MD</u>  |   |  |  |  |  | 8-8-82   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS   |  |  |  |  |  |   |
| MICHAEL R. KESSLER MD   |   | UNIV. of Md. HOSPITAL  |  |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |   |
| Burial  |   | 8/11/82  |  | New Cathedral Cem.   |  | Baltimore COUNTY Maryland                                      |  |   |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave.  |   | AUG 9 1982   |  | John J. Conner   |  |  |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

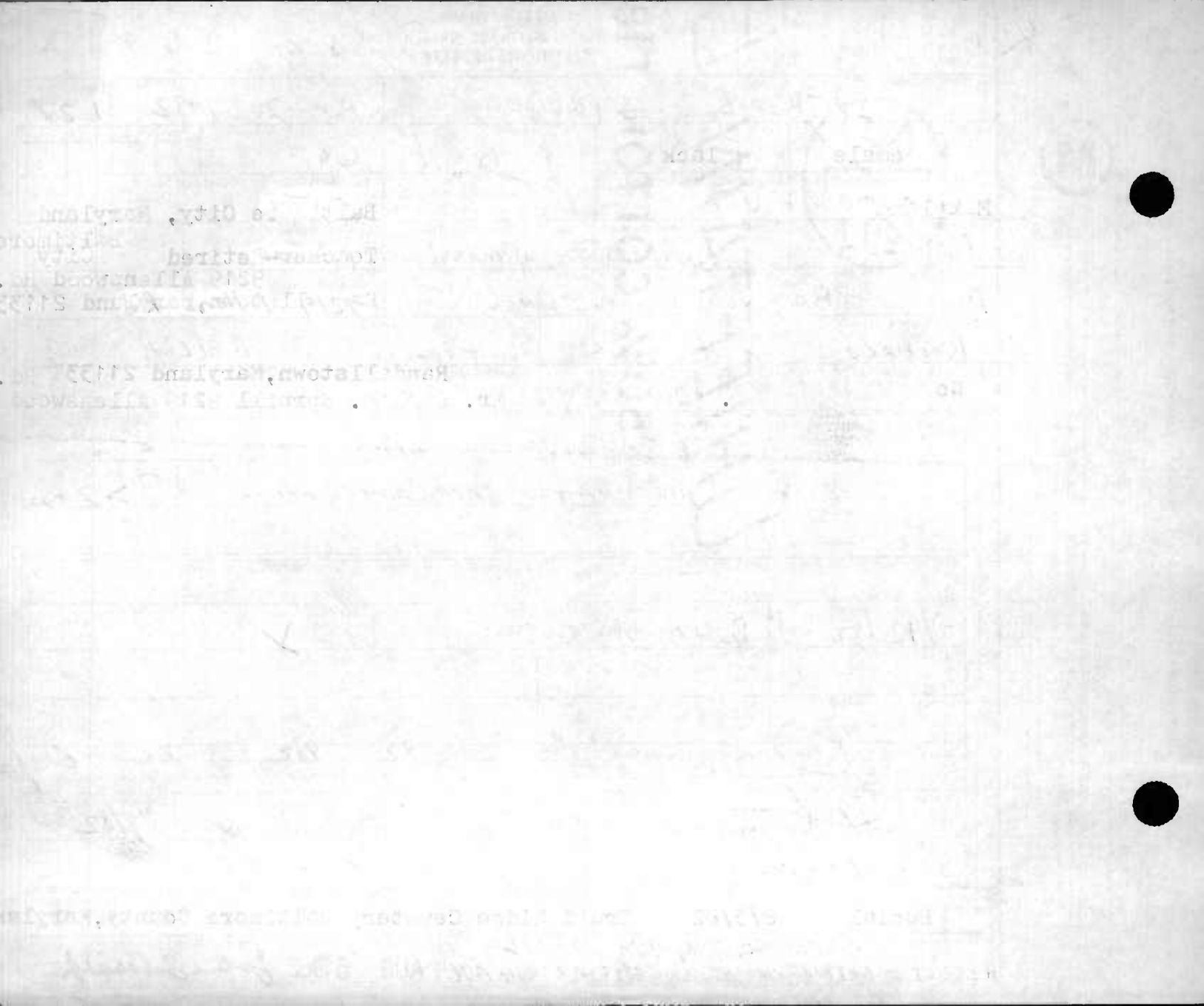
FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 1 2

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDITH B. SPRUILL</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>AUG 2 1982</b>   |   | 2b. HOUR <b>1:20 PM</b>                                 |
| 3. SEX <b>F</b> <b>Female</b>   | 4. RACE <b>Black</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>1 18 16</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, Maryland</b>                         |   |   |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY of Maryland</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher-Retired</b>         |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b> |
| 13a. STATE <b>MD</b>  | 13b. COUNTY <b>BALTIMORE</b>   | 13c. CITY OR TOWN <b>RANDALLSTOWN</b>   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET ADDRESS <b>9219 Allenswood Rd. Randallstown, Maryland 21133</b>   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>RICHARD BOWSER</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRANCIS ROLLINS</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>214 404822</b>  |  | 17. INFORMANT <b>Mr. Earl D. Spruill 9219 Allenswood Rd. Randallstown, Maryland 21133</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>1740 f CARDIOVASCULAR ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC PAPILLARY CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>?</b><br>Approximate interval between onset and death: <b>&lt; 5 min</b><br><b>? &gt; 2 mos.</b> |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>a</b>   |  |   |  |   |   |
| 19a. DATE OF OPERATION <b>7/92/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bowel obstruction</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (1) this hospital attended the deceased from <b>7/9</b> to <b>8/2</b> , 19 <b>82</b> , that (2) I saw the deceased die on <b>8/2</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I saw the body after death, I did not know the body after death.)  |  |   |  |   |   |
| 22b. SIGNATURE <b>S. Kurtzman</b> MD  |  | 22c. DATE SIGNED <b>8/2/82</b>  |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. KURTZMAN</b>  |  | 22f. ADDRESS <b>22 S. Greene ST</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>8/5/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery Baltimore County, Maryland</b>   |   |
| 23d. LOCATION   |  | 24. FUNERAL DIRECTOR <b>BALTIMORE, Maryland 21216</b>   |  |   |   |
| 24. NAME <b>HERBERT E. NUTTER FUNERAL HOME 3035 W. NORTH AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1982</b>   |  |   |   |
| 25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>   |  |   |  |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 0 9 1 3  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| IDA SQUERRINI  |  | AUGUST 8, 1982  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  |
| 5 DATE OF BIRTH<br>3 - 23 - 16   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.   |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |  |
| 10 CITY OR TOWN OF DEATH<br>Balto. Md.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home Hospital |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.  |  | 13b. CITY OR TOWN<br>Balto. City  |  |
| 13c. CITY OR TOWN<br>Balto   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 13e. STREET ADDRESS<br>135 N. Highland Ave   |  | 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alfonso Esposito   |  |
| 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Domenica Attorresse  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                             |  |
| 16b SOCIAL SECURITY NO.<br>212-46-8124   |  | 17 INFORMANT<br>ADDRESS<br>Alfred Squerrini 135 N. Highland Ave.  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>5324 IMMEDIATE CAUSE (a) PULMONARY EMBOLISM<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) GASTRECTOMY<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a DATE OF OPERATION<br>JULY 19, 1982   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>BLEEDING DOUDENAL ULCER  |  |
| 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                          |  |
| 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a I certify that (1) (this hospital) attended the deceased from JULY 17, 19 82, to AUGUST 8, 19 82, that (1) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  | 22b SIGNATURE<br>M T A  |  |
| 22c DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22d DATE SIGNED<br>AUGUST 8, 1982   |  |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT)<br>MOHAMMAD TAQI, MD.   |  | 22f ADDRESS<br>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>8 - 10 - 82   |  |
| 23c NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto Md.  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Joseph N. ZANNINO F.H.  |  | 25a DATE REC'D. BY REGISTRAR<br>AUG 10 1982   |  |
| 25b REGISTRAR'S SIGNATURE<br>John J. Carver  |  | 25c REGISTRAR'S SIGNATURE   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the funeral director. Page 4 should be filed in the office of the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |                             | 8 2 2 0 9 1 4<br>REG. NO.                       |  |  |  |
|--|--|---|--|---|--|---|--|--|-----------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES STAAB</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>8</b> YEAR <b>82</b>              |   |  |  | 7a. HOUR<br><b>11:45 PM</b> |   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>28</b> YEAR <b>03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |                             | IF UNDER 1 YEAR<br>HOURS <b>0</b> MIN. <b>0</b> |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |  |                             |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>S. BALTO GEN HOSP</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sheet Metal Worker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>UNK</b>  |                             |   |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Anne Arundel</b>  |  | 13c. CITY OR TOWN<br><b>Linthicum</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>903 Wanda Road</b>   |                             |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Louis</b> MIDDLE <b>Staab</b> LAST   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b>Hormann</b> LAST |   |  |  |                             |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-20-5054 A</b>  |  | 17. INFORMANT<br><b>Mrs. Catherine McClaskey</b><br>ADDRESS <b>717 Silver Creek Road Balto. Md. 21208</b>   |  |   |  |  |                             |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4290 IMMEDIATE Cause (a) CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RESPIRATORY ARREST</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>CONGESTIVE HEART FAILURE PLEURAL EFFUSION</b> |  |   |  |   |  |   |  |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |                             |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                             |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |                             |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                             |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/6</b> 19 <b>82</b> , to <b>8/8</b> 19 <b>82</b> , that (I) (we) first saw the deceased alive on <b>8/8</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |  |   |  |   |  |  |                             |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                             | 22c. DATE SIGNED<br><b>8/8/82</b>               |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ZIGEL</b>  |  |   |  |   | 22e. ADDRESS<br><b>3000 S. HANOVER ST BALTO 21230</b>                        |   |  |  |                             |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8-12-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery Baltimore City, Maryland</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |                             |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 10 1982</b>                          |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |                             |   |  |  |  |

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Items 13a-e per phone 9/2/82 dad STATE OF MARYLAND  
 FOR  
 1 - STATE REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 REG. NO. 8 2 2 0 9 1 5

|  |  |   |   |   |  |  |   |  |  |
|--|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>STAMPER, STEVEN   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 18 82                          |   |  | 2b. HOUR<br>700 AM   |   |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 4 82  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>0 14 -  |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>-----  |   | 13c. CITY OR TOWN<br>Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>RICKY ----- EASTER   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ADRIENNE ----- STAMPER |   |  | 16. STREET ADDRESS<br>801 N. Woodington Rd.<br>BALTIMORE MD 21229  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADRIENNE 801 N. WOODINGTON RD<br>BALTIMORE MD  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST - CARDIAC ARREST</u><br>7684<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEVERE ACIDOSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>B-STREPTOCOCCUS PNEUMONIA.</u><br>14 DAYS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 HRS. |  |   |   |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><u>PREMATURITY</u>  |  |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 4</u> , 19 <u>82</u> , to <u>AUGUST 18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br>Mary LeVore Keszler MD   |  |   | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>8-18-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARY LEVORE KESZLER M.D.  |  |   | 22e. ADDRESS<br>22. S. GREE ST. BALTIMORE MD.                           |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |  | 23b. DATE<br>8/26/82  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Anatomy Board Balto., Md.  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 31 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Chalk  |   |  |  |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

1

801 W. Washington St.  
Chicago, Ill. 60601

DAVE

PO BOX 1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer or death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 0 9 1 6<br>REG. NO.   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOHN M. STANICH</b>  |  |  |  | August 19, 1982   |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>January 19, 1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>65</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Layoutman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sparrows-point</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br><b>Maryland - Baltimore</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John - Stanich</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary - Drobotinich</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-09-8725</b>   |  | 17. INFORMANT ADDRESS<br><b>Larry Stanich 4805 Drexel Rd. (20740)</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>6 hours</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>21d. INJURY OCCURRED</b>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/20</b> , 19 <b>82</b> , to <b>8/17/82</b> , 19 <b>82</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>8/17/82</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If <input type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Robert R. Kent M.D.</b>  |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>                    |  | 22c. DATE SIGNED<br><b>8/21/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Robert Kent</b>   |  |  |  | 22e. ADDRESS<br><b>4419 Falls Rd.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Aug. 23, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Lilly &amp; Zeiler Inc.</b>   |  |  |  | ADDRESS<br><b>1901 Eastern Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 24 1982</b>   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>  |  |   |  |



|           |                         |                  |                          |
|-----------|-------------------------|------------------|--------------------------|
| John      | 4.                      | WATSON           | August 10, 1922          |
| Wife      | White                   | January 12, 1917 | 25                       |
| Baltimore | United States           | X                | Baltimore City           |
| Baltimore | Baltimore City Hospital | Legation         | Department of            |
| Maryland  | -                       | -                | 500 River Ave.           |
| John      | -                       | Went             | Proclamation             |
| NO        | -                       | 21-08-25         | James standing with (20) |

*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*

Dr. Robert Kane  
Baltimore  
Baltimore Co., Md.  
Baltimore  
Baltimore



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with next of kin after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 1 7

REG. NO.

|  |   |   |                   |  |  |  |  |      |   |
|--|---|---|-------------------|--|--|--|--|------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST   | MIDDLE            | LAST   | 2a. DATE OF DEATH  | MONTH                                      | DAY  | YEAR | 2b. HOUR  |
| BENJAMIN LEONADR STANLEY   |   |   |                   |  | 08-31-82   |  |  |      | 7:45pm  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |      |   |
| MALE   | WHITE   | 3/16/1907   |                   | 75   | MONTHS DAYS  |  | HOURS MIN.   |      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |      |   |
| MARYLAND   | U.S.A.  |   |                   | BALTIMORE CITY MD.   |  |  |  |      |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |      |   |
| BALTIMORE  | CHURCH HOSPITAL CORP.   |   |                   | SEAMAN   |  |  | MARINETINE   |      |   |
| 13a. STATE   |   | 13b. COUNTY   | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS                                      |  |  |      |   |
| MARYLAND   |   | BALTIMORE   | WHITE MARSH       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 11318 BIRD RIVER GROVE RD. WHITE MARSH MD.               |  |  |      |   |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |                   |  |  |  |  |      |   |
| PETER STANIEWICZ   |   | HELEN MAYKA   |                   |  |  |  |  |      |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT  |  |  |  |      |   |
| NO   |   | 216 10 0057   |                   | MARY E. STANLEY GROVE RD. MARYLAND   |  |  |  |      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |   |   |                   |  |  |  |  |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 4439 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST   |   |   |                   |  |  |  |  |      |   |
| DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS SCROTAL ABSCESS RIGHT INGUINAL ABSCESS   |   |   |                   |  |  |  |  |      |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) PERIPHERAL VASCULAR DISEASE   |   |   |                   |  |  |  |  |      |   |
| PART 2. OTHER SIGNIFICANT DISEASES OR CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>(1.) CONGESTIVE HEART FAILURE CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CARCINOMA LUNG  |   |   |                   |  |  |  |  |      |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |      |   |
| 08-13-82   |   | DRAINAGE OF ABSCESS   |                   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |  |  |      |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |      |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 08-05-19 82, to 08-31-19 82, that (I/we) last saw the deceased alive on 08-31-19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did/did not view the body after death. |   | 22b. SIGNATURE<br>V. Balakrivhnan   |                   |  | 22c. DATE SIGNED   |  |  |      |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |                   |  |  |  |  |      |   |
| DR. BALAKRIVHMAN M.D.  |   | CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY BALTIMORE, MARYLAND 21231  |                   |  |  |  |  |      |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |      |   |
| BURIAL   |   | 9/3/1982  |                   | HOLY CROSS CEM.  |  | BROOKLYN MARYLAND                          |  |      |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |   |   |                   | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE                            |  |  |  |      |   |
| DIPPEL FUNERAL HOMES BALTIMORE MARYLAND  |   |   |                   | SEP 2 1982 John J. Canfield  |  |  |  |      |   |



RECEIVED  
JAN 10 1964  
U.S. AIR FORCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 1B above any injury, or other traumatic event, the medical examiner must be notified and a copy of the report filed with this certificate.)

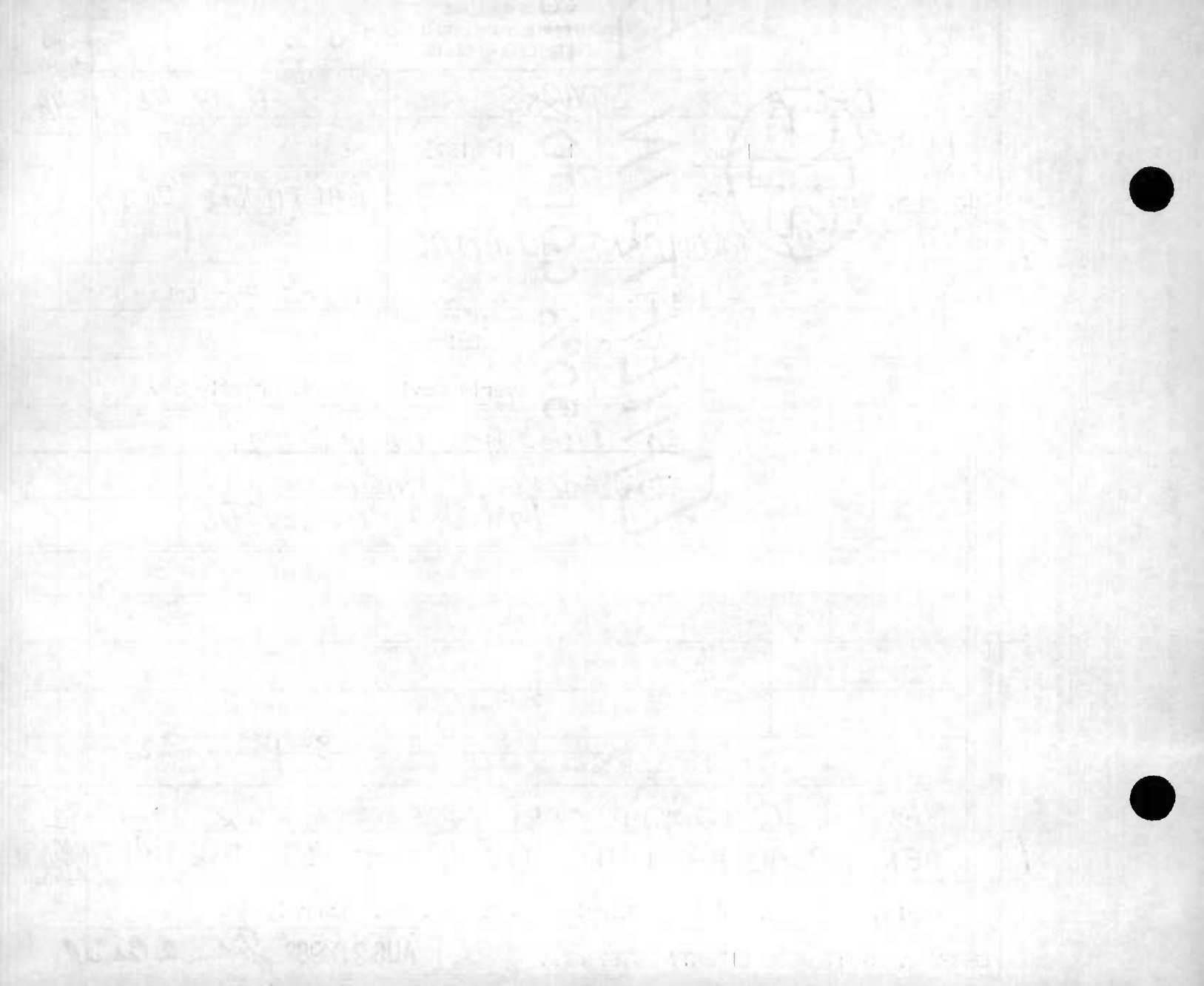
FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 1 8

REG. NO.

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DELLA STARKS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 18 82</b>                  |   |  | 2b. HOUR<br><b>11-43<sup>AM</sup></b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 11 1893</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Durham N. Car.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>13b. COUNTY</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>717 Druid Park Lake DR</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joe Tucker</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lula</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Beverly Davis 606 N. Grantly St.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>5751<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>unresolved pneumonia</b><br>(c) <b>probable cholecystitis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>8-18</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8-18</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Sher Afzal Hashmi</b>   |  |  | DEGREE<br><b>Md</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8-18-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SHER AFZAL HASHMI</b>  |  |  | 22e. ADDRESS<br><b>PROVIDENT HOSPITAL BALTIMORE MD</b>                 |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>   |  |  | 23b. DATE<br><b>8/23/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Nat. Mem. Pk.</b>            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 20 1982</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |                                   |                            |  |
|--|--|--|--|--|--|--|-----------------------------------|----------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR   |                                   |                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR   |                                   |                            |  |
| James H. Starliper   |  | 8 27 82  |  |  |  | 6:00AM   |                                   |                            |  |
| 3 SEX  | 4 RACE   | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.           |  |
| Male   | Cauc.  | 8 22 13  |  | 69 YRS.  |  | MONTHS DAYS  |                                   | HOURS MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |                                   |                            |  |
| Maryland   | U.S.A.   |  |  | Baltimore City MD.   |  |  |                                   |                            |  |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |                            |  |
| Baltimore  | South Balti. Gen Hosp.   |  |  | Machinist  |  |  | Beth. Steel                       |                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |                                   |                            |  |
| Maryland   |  | Baltimore  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 506 S. 45th Street   |                                   |                            |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  |  |  |  |                                   |                            |  |
| James A. Starliper   |  | Lacey Mae Butts  |  |  |  |  |                                   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS   |  |  |                                   |                            |  |
| No   |  | 213-09-0176  |  | 506 S. 45th Street Donna M. Starliper-Balto., MD. 21224                        |  |  |                                   |                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |                                   |                            |  |
| IMMEDIATE CAUSE (a) Renal failure  |  |  |  |  |  |  |                                   |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic Heart Disease   |  |  |  |  |  |  |                                   |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |                                   |                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |                                   |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |                                   |                            |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                                   |                            |  |
|  |  | 19 P.M.  |  |  |  |  |                                   |                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET   |  | CITY OR TOWN   |                                   | COUNTY STATE               |  |
|  |  |  |  |  |  |  |                                   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19 1982, to 8/27 1982, that (I) (we) last saw the deceased alive on 8/27 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |                                   |                            |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED           |  |
| J.L. Soler M.D.  |  |  |  |  |  |  |                                   | 8/27/82                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |                                   |                            |  |
| J.L. Soler M.D.  |  |  |  | 3001 S Hanover St. Balt. MD.   |  |  |                                   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN   |                                   | COUNTY STATE               |  |
| Burial   |  | 8/30/1982  |  | Gardens Of Faith   |  | Baltimore  |                                   | Maryland                   |  |
| 24 FUNERAL DIRECTOR NAME   |  |  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE |  |
| Duda-Ruck, Inc.  |  |  |  | 7922 Wise Avenue Dundalk, MD. 21222  |  | AUG 31 1982  |                                   | John J. Canick             |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 2 0  
REG. NO.

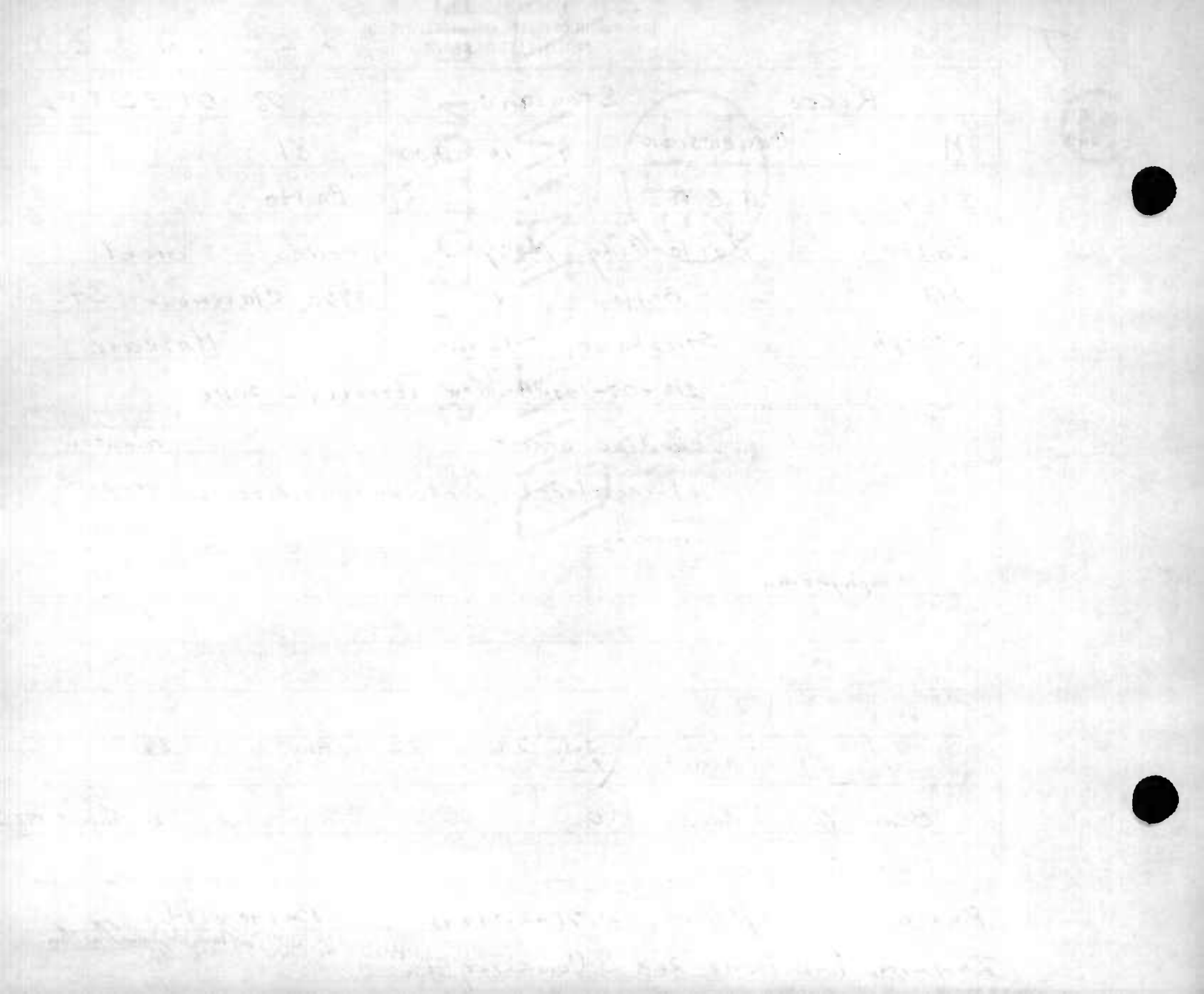
|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Rocco Stassano</b>                                       |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 01 82</b>                              |   | 2b. HOUR<br><b>8:30 P.M.</b>                                    |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 16 1900</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto.</b> MD.                                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. City Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b> |   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3920 Claremont St.</b>                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Stassano</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fannie Moscato</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.<br><b>213-07-3075</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Andrew Petrelli - HOME</b>                                       |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>atherosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>smoking</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>minutes.</b><br><b>years.</b><br><b>years.</b> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **emphysema**

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 29</b> , 19 <b>82</b> , to <b>Aug 1</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1 August</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Blair J. Andrew M.D.</b>  |  | DEGREE<br><b>M.D.</b>  |  |   | 22c. DATE SIGNED<br><b>1 August 1982</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Blair J. Andrew</b>  |  | 22e. ADDRESS   |  |   |   |

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                        | 23b. DATE<br><b>8/3/82</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ZANNINO FUN. HOME-263 S. CONKLING ST.</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG - 2 1982</b>        |   |





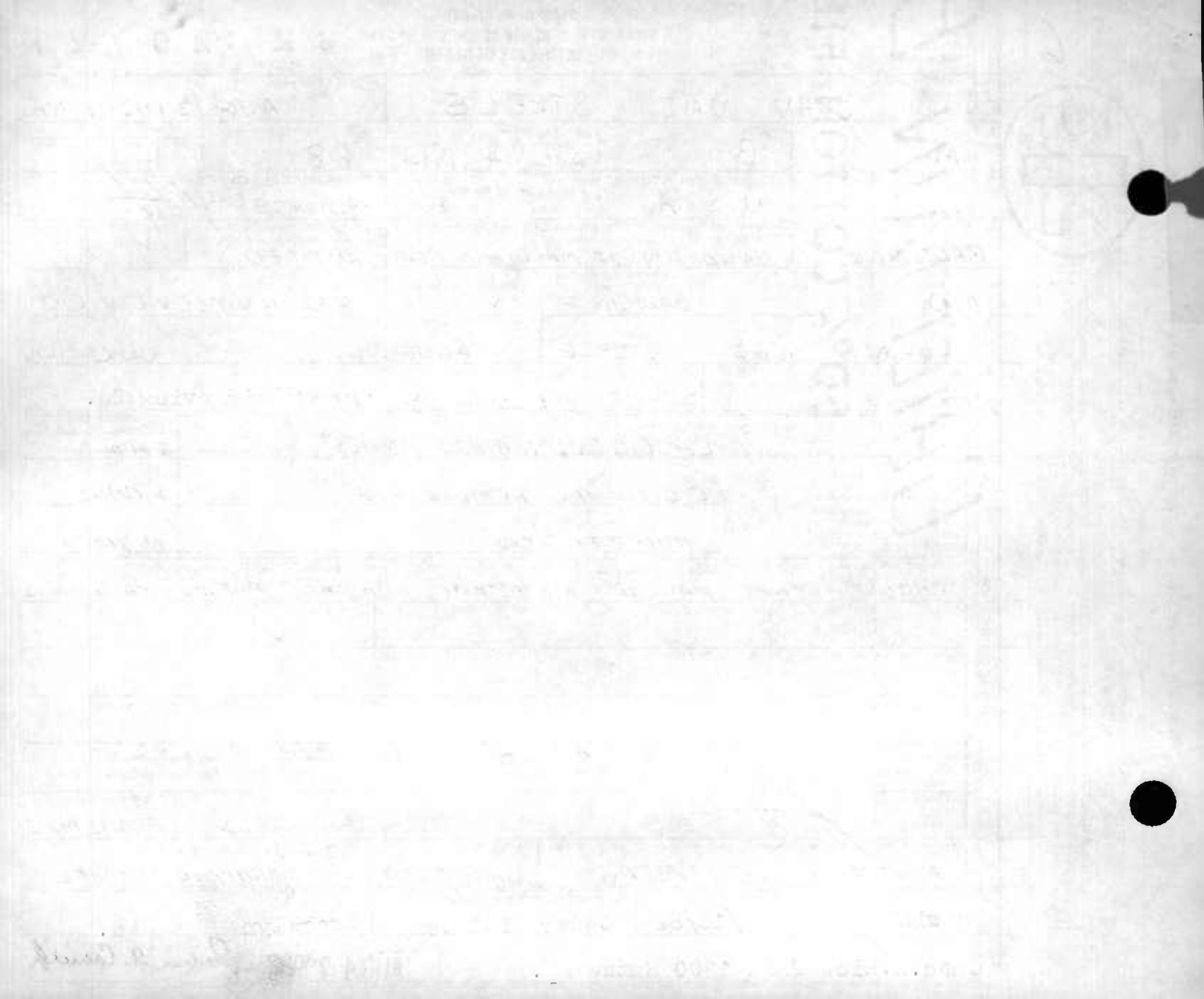
item 7a #G570 8/31/82 ph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 2 1

REG. NO.

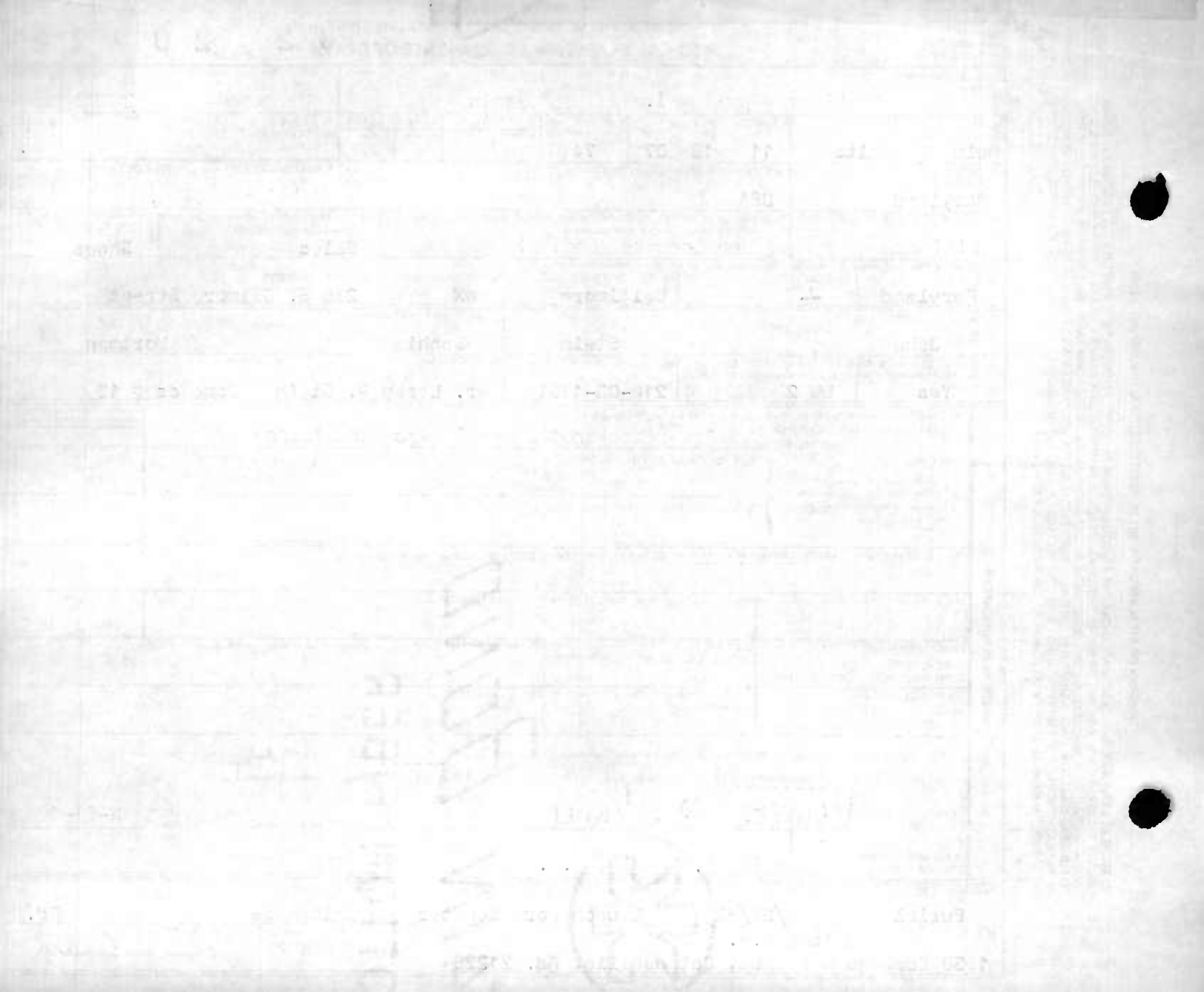
|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1- FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  | MONTH DAY YEAR  |   | MONTHS DAYS HOURS MIN.  |  |
| JOHN NMI STEELE   |  | AUG 12 1982   |   | 11:30 AM  |  |
| 3 SEX   | 4 RACE   | 5. DATE OF BIRTH  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      | IF UNDER 1 YEAR   |  |
| M   | B  | MONTH DAY YEAR  | 68  | MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |   |  |
| S.C.  | U.S.A.   |   | BALTIMORE CITY MD.  |   |  |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |   | 12b KIND OF BUSINESS OR INDUSTRY             |
| BALTIMORE   | UNIVERSITY OF MARYLAND HOSP  |   | RETIRED   |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b STATE  | 13c CITY OR TOWN  | 13d INSIDE CITY LIMITS?   | 13e STREET ADDRESS  |  |
| MD  |  | BALTIMORE   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 832 BRIDGEVIEW RD   |  |
| 14 FATHER'S NAME  | 15 MOTHER'S MAIDEN NAME  |   | ADDRESS   |   |  |
| JOHN NMI STEELE   | AGNES  |   | UNKNOWN   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b SOCIAL SECURITY NO.  | 17 INFORMANT ADDRESS  |   |   |  |
| UNKNOWN   | 217-05-9009  | Laura Steele 832 Bridgeview Rd.   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) 4310 CARDIORESPIRATORY ARREST   |  |   |   |   | 5 MIN  |
| DUE TO, OR AS A CONSEQUENCE OF (b) OCCIPITAL HEMORRHAGE   |  |   |   |   | 6 DAYS                                       |
| DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION   |  |   |   |   | 10 YEARS                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |   |   |  |
| CHRONIC RENAL FAILURE, METASTATIC PROSTATIC ADENOCARCINOMA  |  |   |   |   |  |
| 19a DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a AUTOPSY?  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
|   | HOUR A.M. MONTH DAY YEAR   |   |   |   |  |
|   | P.M. 19  |   |   |   |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY   | 21f. LOCATION   |   |   |  |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG 8, 19 82, to AUG 12, 19 82, that (I) (we) last saw the deceased alive on AUG 12, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE  |  | DEGREE  |   | 22c. DATE SIGNED  |  |
|   |  |   |   | AUG 12 1982   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e ADDRESS   |   |   |  |
| ANASTACIO DE CASTRO   |  | 22 S. GREEN UNIVERSITY OF MARYLAND HOSPITAL   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION   | CITY OR TOWN COUNTY STATE                                     |  |
| BURIAL  | 8/18/82  | Cedar Hill Cem  | Brooklyn  | Md.   |  |
| 24 FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                                    |  |
| NAME Chas.A. Rice FHPA 1300 Eutaw P.  |  | AUG 17 1982   |   | John J. Carver  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |   |   |   |  |  |  |  | REG. NO. 2 20922 |  |
|--|------------------|--|---|---|---|--|--|--|--|------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Walter I. Stein   |                  |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>8 22 1982 |  | 7b. HOUR<br>M<br>12:59 P.M.                |  |                  |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 19 07   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>74 YRS.                   | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>8 22 1982  |  | 2d. HOUR<br>P.M.                           |  |                  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |  |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shoes |  |                  |  |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY<br>--  | 13c. CITY OR TOWN<br>Baltimore                                  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>238 S. Gilmore Street   |  |  |  |                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Stein   |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sophia Wortman |   |   |  |  |  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |                  | (IF YES, GIVE WAR OR DATES)<br>WW 2  |   | 16b. SOCIAL SECURITY NO.<br>216-03-1797   |   | 17. INFORMANT<br>ADDRESS<br>Mr. Leroy P. Stein Same as # 13  |  |  |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 10.   |                  |  |   |   |   |  |  |  |  |                  |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |  |  |                  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |  |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |                  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |   |   |  |  |  |  |                  |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell  |                  | TITLE (SPECIFY)<br>M.D. Assistant  |   | MEDICAL EXAMINER  |   | DATE SIGNED<br>8-23-82   |  |  |  |                  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |                  | ADDRESS<br>111 Penn Street   |   |   |   |  |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>8/25/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  |  |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Witzke P.A.<br>1630 Edmondson Avenue, Catonsville, Md. 21228   |                  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 26 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |  |  |                  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 0 9 2 3<br>REG. NO.  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Aguilla</b> <b>Stephen S O N</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Aug - 11, 1982</b> 2b. HOUR <b>11 10</b> M   |  |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 19 97</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt.</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Balt.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Seton Hill Nursing Home</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |   |  |
| 13a. STATE <b>md.</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Aguilla</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Geetude Anderson</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>   |  | 16b. SOCIAL SECURITY NO. <b>215-14-9874</b>   |  | 17. INFORMANT ADDRESS <b>N. Home Administration Record</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1579</b> IMMEDIATE CAUSE (a) <b>Cancer of Pancreas</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b> |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-4</b> , 19 <b>82</b> , to <b>8-11</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8-11</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Yanni Pungolem</b> DEGREE _____  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>8/13/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>8-16-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Cem</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>William C. Brown</b> ADDRESS <b>1206 W. North Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1982</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Carney</b>  |  |   |  |





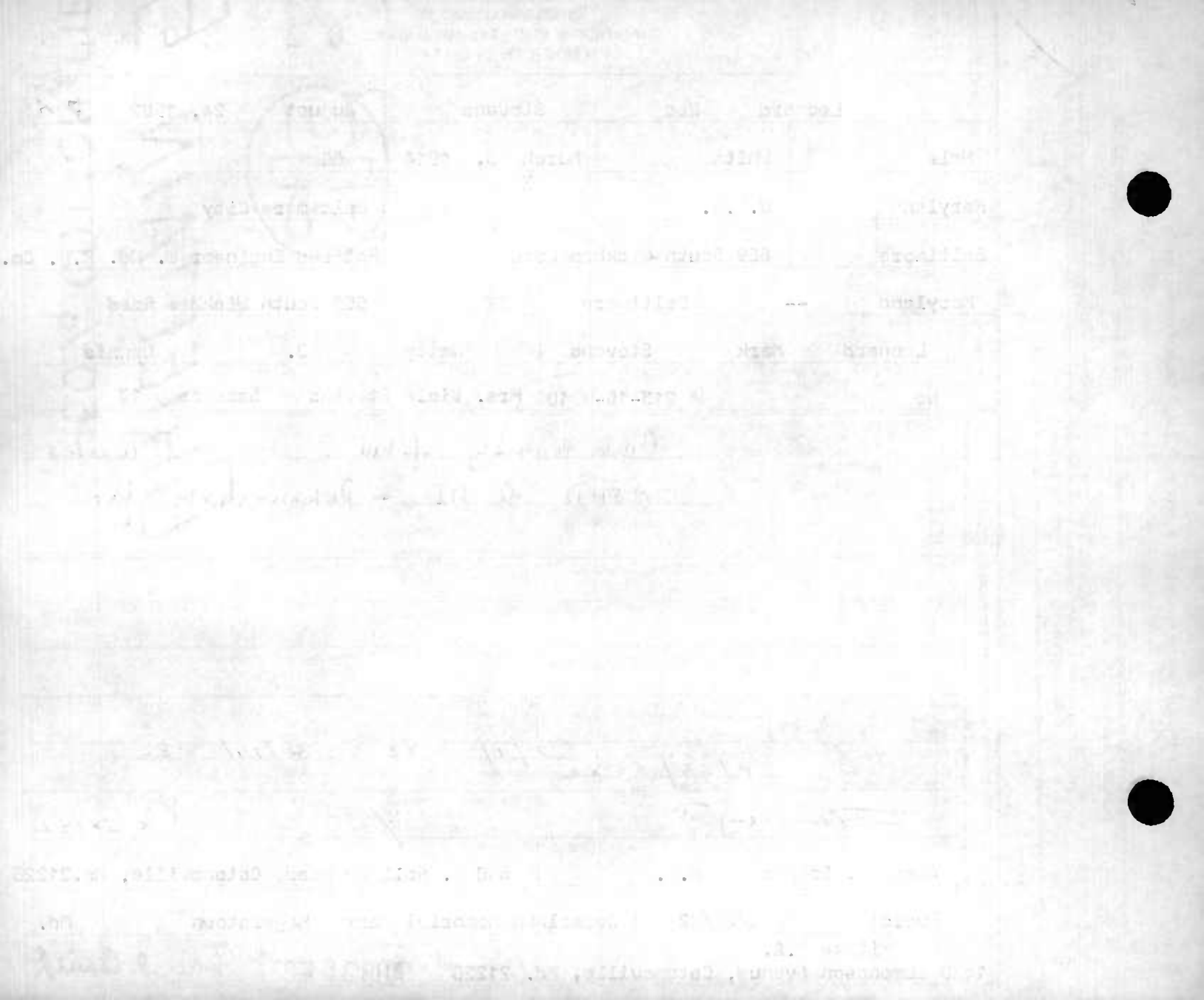
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                              |  |   |  |                                    |  |  |  | 8 2 2 0 9 2 4   |  |                                   |  |   |  |
|---|--|------------------------------|--|---|--|------------------------------------|--|--|--|---|--|-----------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR  |  |                              |  |   |  |                                    |  |  |  | CERTIFICATE OF DEATH  |  |                                   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |                              |  |   |  |                                    |  |  |  | 2a. DATE OF DEATH   |  |                                   |  | 2b. HOUR  |  |
| FIRST MIDDLE LAST<br><b>Leonard Ned Stevens</b>   |  |                              |  |   |  |                                    |  |  |  | MONTH DAY YEAR<br><b>August 24, 1982</b>  |  |                                   |  | <b>8 4 M</b>  |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH  |  |                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                  |  |   |  |
| <b>Male</b>   |  | <b>White</b>                 |  | MONTH DAY YEAR<br><b>March 5, 1914</b>  |  |                                    |  | <b>68</b> YRS.   |  | MONTHS DAYS   |  | HOURS MIN.                        |  |   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |                                   |  |   |  |
| <b>Maryland</b>   |  | <b>U.S.A.</b>                |  |   |  |                                    |  | <b>Baltimore City</b> MD.  |  |   |  |                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |
| <b>Baltimore</b>  |  |                              |  | <b>659 South Wickham Road</b>   |  |                                    |  | <b>Retired Engineer</b>  |  |   |  | <b>W. Md. R.R. Co.</b>            |  |   |  |
| 13a. STATE  |  |                              |  |   |  |                                    |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                 |  | 13d. INSIDE CITY LIMITS?  |  |
| <b>Maryland</b>   |  |                              |  |   |  |                                    |  |  |  | <b>--</b>   |  | <b>Baltimore</b>                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  |                              |  |   |  |                                    |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                   |  |   |  |
| FIRST MIDDLE LAST<br><b>Leonard Mark Stevens</b>  |  |                              |  |   |  |                                    |  |  |  | FIRST MIDDLE LAST<br><b>Netty J. Dennis</b>   |  |                                   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |                              |  | 16b. SOCIAL SECURITY NO.  |  |                                    |  | 17. INFORMANT  |  |   |  | ADDRESS                           |  |   |  |
| <b>No</b>   |  |                              |  | <b>A 213-18-9910</b>  |  |                                    |  | <b>Mrs. Viola Stevens</b>  |  |   |  | <b>Same as # 13</b>               |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4140 Cardio Respiratory failure</b>   |  |                              |  |   |  |                                    |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>   |  |                                   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASHD MI in Parkinson disease</b>   |  |                              |  |   |  |                                    |  |  |  | Years <b>Years</b>  |  |                                   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |                              |  |   |  |                                    |  |  |  |   |  |                                   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |                              |  |   |  |                                    |  |  |  |   |  |                                   |  |   |  |
| 19a. DATE OF OPERATION  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |                                   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/1/82</b> to <b>8/24/82</b> , that (I) (we) last saw the deceased alive on <b>8/23/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |   |  |                                    |  |  |  |   |  |                                   |  |   |  |
| 22b. SIGNATURE <b>Adnan M. Sonmez</b>   |  |                              |  | DEGREE <b>M.D.</b>  |  |                                    |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED <b>8/24/82</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                              |  | 22e. ADDRESS  |  |                                    |  |  |  |   |  |                                   |  |   |  |
| <b>Adnan M. Sonmez</b>  |  |                              |  | <b>M.D.</b>   |  |                                    |  | <b>500 N. Rolling Road, Catonsville, Md. 21228</b>   |  |   |  |                                   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                   |  |   |  |
| <b>Burial</b>   |  |                              |  | <b>8/27/82</b>  |  | <b>Cedarlawn Memorial Park</b>     |  |  |  | <b>Hagerstown Md.</b>   |  |                                   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Witzke P.A.</b>  |  |                              |  |   |  |                                    |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE        |  |   |  |
| <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>  |  |                              |  |   |  |                                    |  |  |  | <b>AUG 26 1982</b>  |  | <b>Joan J. Conish</b>             |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | 7 2 2 0 9 2 5   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT J STEWART</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>24</b> YEAR <b>82</b>   |  | 2b. HOUR<br><b>3:55 PM</b>   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>29</b> YEAR <b>06</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>76</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 23 HRS<br>HOURS <b>0</b> MIN. <b>0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSP BALTO MD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>NOAH</b> MIDDLE <b>STEWART</b> LAST <b>STEWART</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>SYLVIA</b> MIDDLE <b>CHADWELL</b> LAST <b>CHADWELL</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>249-12-2842</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Robert J. Stewart Jr. 1039 McDonough St</b>  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100</b><br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SUSPECTED MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>CORONARY ARTERY DISEASE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br><b>911, McDonough BALTO MD</b>   |  | CITY OR TOWN   |  | COUNTY   |  | STATE   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>8/14</b> , 19 <b>82</b> , to <b>8/24</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/24</b> , 19 <b>82</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Mary E. Carroll</b> MD.  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/24/82</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARY E. CARROLL</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>MERCY HOSPITAL, BALTO MD.</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8/28/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Eternal</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD.</b> STATE <b>MD.</b>  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b>  |  |   |  |   |  | ADDRESS<br><b>1101 E. North Avenue</b>   |  | 25. INTERVIEWED BY REGISTRAR<br><b>Aug 26 1982</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  | REG. NO. |  |
|---|--|---|--|--|--|--|--|---|--|----------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |  |  |   |  | 82 20926 |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILLIAM H. STEWART   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8/11/82  |  | 2b. HOUR<br>6:32 AM   |  |          |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5/18/1906   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |          |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |   |  |          |  |
| 12. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |  |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LABORER  |  | 15. KIND OF BUSINESS OR INDUSTRY<br>Various   |  |          |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE MD. 17b. CITY OR TOWN CHESTER   |  |   |  |  |  | 18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 19. STREET ADDRESS<br>RFD #1  |  |          |  |
| 20. FATHER'S NAME FIRST MIDDLE LAST<br>HENRY STEWART  |  |   |  | 21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CORA T. UHMAN  |  |  |  |   |  |          |  |
| 22a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  |   |  | 22b. SOCIAL SECURITY NO.<br>213-05-7262  |  | 23. INFORMANT NAME ADDRESS<br>MRS. J. STEWART<br>CHESTER TOWN, MD.   |  |   |  |          |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>5070 IMMEDIATE CAUSE (a) Severe Metabolic acidosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Shock & Renal shut down<br>DUE TO, OR AS A CONSEQUENCE OF<br>Massive Aspiration pneumonia.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  |  |   |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Duodenal obstruction  |  |   |  |  |  |  |  |   |  |          |  |
| 25a. DATE OF OPERATION<br>—   |  | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  |  |  | 26a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |          |  |
| 28a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE AT WORK <input type="checkbox"/>  |  | 28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 28c. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |          |  |
| 29a. I certify that (I) (this hospital) attended the deceased from 8/10/82, to 8/11/82, that (I) (we) last saw the deceased alive on 8/11/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  |          |  |
| 29b. SIGNATURE<br>A. Agazarian  |  |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 29c. DATE SIGNED<br>8/11/82   |  |          |  |
| 29d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SARKIS AGHAZARIAN  |  |   |  |  |  | 29e. ADDRESS<br>UNION MEMORIAL HOSPITAL  |  |   |  |          |  |
| 30a. BURIAL, CREMATION, REMOVAL (TYPE)<br>BURIAL  |  | 30b. DATE<br>8/14/82  |  | 30c. NAME OF CEMETERY OR CREMATORY<br>Mt Pleasant  |  | 30d. LOCATION CITY OR TOWN COUNTY STATE<br>CHESTER TOWN MD.  |  |   |  |          |  |
| 31. FUNERAL DIRECTOR<br>Joseph W. [unclear]   |  |   |  |  |  | 32. DATE REC'D. BY REGISTRAR<br>AUG 16 1982  |  | 33. REGISTRAR'S SIGNATURE<br>John J. [unclear]  |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 2 7

REG. NO.

|  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR  |  |
|  |  | William Stokes   |  |  |  | 8 28 82   |  | 1:30 p.m.   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| male   |  | Black  |  | 8 1 09   |  | 73 YRS.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | MD.   |  |
| VA   |  | U.S.A.   |  |  |  | City  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| Baltimore  |  | Univ. of Maryland Hospital   |  | Retired  |  |   |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS                                     |  |
| Md.  |  | Baltimore  |  | City   |  |   |  | 851 George St. Apt. 141                                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                                   |  |
| Unknown  |  | Carrie   |  |  |  | 213-09-5176   |  | William Stokes Jr. 105 So. Calhoun                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART I. DEATH WAS CAUSED BY  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)  |  | DUE TO, OR AS A CONSEQUENCE OF (c)                      |  |
| 4275   |  | Cardiac Arrest.  |  |  |  |   |  |   |  |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.   |  |  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  | Seizures   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug. 9-11, 1982, to Aug. 28, 1982, that (I) (we) lost the deceased alive on Aug. 28, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |
|  |  | Ernesto Potes  |  | M.D.   |  | 8/28/82   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                     |  |   |  |   |  |
| Ernesto Potes  |  | 925 N. Colvert S. 21202.   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| Buried   |  | 9/2/82   |  | Md. Vet. Cem.  |  | Crownsville Md.   |  |   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Wm. C. March F/H   |  | 1101 E. North  |  | AUG 31 1982  |  | John J. Conner  |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 26 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   | REG. NO. <b>20928</b>  |  |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Alys L. Strauss</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>August 1, 1982</b>                         |  | 2b. HOUR<br><b>10:00 P</b>                                   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 10, 1903</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS                                  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 28 HRS HOURS MINS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Long Green Nursing Home</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS<br><b>7012 Kenleigh Rd.</b>              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Oakland K. Lanpher</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth Abrams</b>   |   | 16. ADDRESS<br><b>114 Armagh Dr. 21212</b>                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO<br><b>212-12-1148</b>   |   | 17. INFORMANT<br><b>Frederick R. Buck, Jr.</b>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>Cerebral Vasculature accident</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 da</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral A-S</b> <b>2 yr</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/24/82</b> to <b>8/1</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (I) (we) did not view the body after death, <b>7/29</b> 19 <b>82</b>   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Norman R. Freeman, Jr.</b>   |  | DEGREE <b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>8/2/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Norman R. Freeman, Jr. M.D.</b>   |  | 22e. ADDRESS<br><b>11 W. 29th St. Baltimore, Md. 21218</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Aug. 3, 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>                        |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>  |  | 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>   |   |  |  |
| 25a. DATE REC'D. BY REG. CLERK<br><b>AUG 6 1982</b>   |  | 25b. REG. CLERK'S SIGNATURE<br><b>John J. [Signature]</b>   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this must be reported to the coroner or medical examiner.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |   |  |   | 8 2 2 0 9 2 9  |   |  |
|--|--|---|--|--|--|---|---|--|---|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR   |  |   |  |  |  |   |   |  |   | REG. NO.   |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Thelma M Strawder  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 6 82                                  |   |   | 2b. HOUR<br>M  |   |  |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>2 27 16   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                   |   | 7a. UNDER 1 YEAR<br>MONTHS DAYS  |   | 7b. UNDER 24 HRS<br>HOURS MIN.                           |   |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                        |   |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>806 W. 35th Street |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  | 13e. STREET ADDRESS<br>806 W. 35th Street |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles E. Clinedinst   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Virginia Bryant          |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-10-3223  |  | 17 INFORMANT<br>ADDRESS<br>Alvin Strawder 806 W. 35th St. Balto. Md. 21211   |  |   |   |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |  |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>24 hr |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 8/8/82, 19____, to 8/9/82, 19____, that (1) (we) last saw the deceased alive about 8/8/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not see the body after death. |  |   |  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Richard L. Diamond   |  |   |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>8-9-82                               |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard L. Diamond  |  |   |  |  | 22e. ADDRESS<br>3547 Chestnut Ave Balto 21211                                  |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery                   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz  |  |   |  |  | ADDRESS<br>3818 Roland Ave. Balto 21211  |   |   | 25a. DATE REC'D BY REGISTRAR<br>AUG 11 1982  |   |  |   |  |

Homeless Park Cemetery Baltimore

3413 Charles Ave. Baltimore 21211

Robert L. Diamond  
3413 Charles Ave. Baltimore 21211

Myron L. Diamond

212-10-3223 14th Street N.W. Wash. D.C. 20004

Charles E. Diamond

Baltimore 21211

300 W. 35th Street

Baltimore

Baltimore

U. S. A.

Baltimore

White

27 10 66

Thomas M. Diamond

6 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 2 0 9 3 0<br>REG. NO.   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) HELEN W. MIDDLE LAST STULTZ   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |  |
| 3. SEX Female  |  |  |  | 4. RACE Caucasian   |  |   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 7 3 03   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MD   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION ST. AGNES HOSPITAL  |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY EDUCATION   |  |   |  |
| 13a. STATE MD  |  |  |  | 13b. COUNTY BALTO. COUNTY   |  |   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Charles WILHIE   |  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) SUSAN SIGLER   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |  |  | 16b. SOCIAL SECURITY NO. 217-46-2872  |  |   |  |
| 17. INFORMANT DOROTHY H. BRANDT  |  |  |  | ADDRESS 195 NEWBURG AVENUE  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>4275 IMMEDIATE CAUSE (a) CAUDOPHIMANY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION 6/4/82  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intubation Left Hip 5/7/1 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/3, 19 81, to 8/1, 19 82, that (I) (we) lost saw the deceased above, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we had not view the body after death.) |  |  |  |   |  |   |  |
| 22b. SIGNATURE S. Ackley MD  |  |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 8/1/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Ackley MD   |  |  |  | 22e. ADDRESS ST. AGNES HOSPITAL, Baltimore, MD  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  | 23b. DATE 08-04-82   |  | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND   |  |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 21229 AUG - 2 1982  |  | 25b. REGISTRAR'S SIGNATURE  |  |

Handwritten notes at the top of the page, including "1000" and "10000".

Handwritten notes in the middle section, including "10000" and "1000".

Handwritten notes in the lower middle section, including "1000" and "10000".

Handwritten notes at the bottom of the page, including "1000" and "10000".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

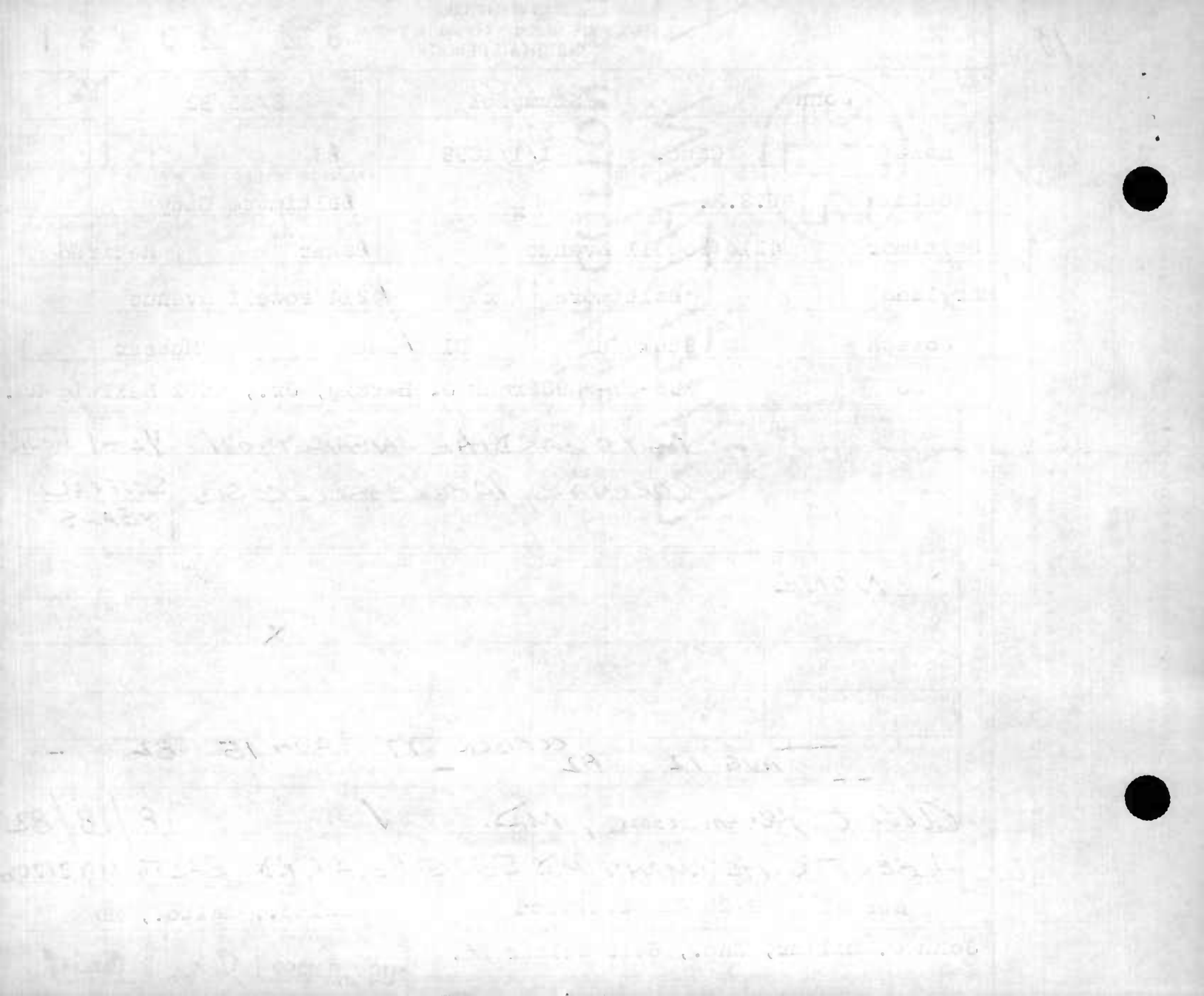
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be signed by the medical examiner.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 8 2 2 0 9 3 1   |  | REG. NO.  |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Stumpf   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8/15/82   |   | 2b. HOUR<br>M                                       |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Cauc.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1/1/1899  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Austria   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4214 Powell Avenue |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Baker                       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>4214 Powell Avenue   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Stumpf  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Musser  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>195-07-2898  |  | 17. INFORMANT<br>ADDRESS<br>Frank J. Herzig, Jr., 4602 Hellwig Rd.  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CORONARY ATHEROSCLEROSIS</u><br>SEVERAL YEARS.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>                             |  |   |  |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>12-1 HOUR |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>NONE</u>  |  |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 19 77</u> to <u>AUG 15 19 82</u> , that (I) (we) lost<br>saw the deceased alive on <u>AUG 12 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><u>Albert C. Herrmann, M.D.</u>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>8/18/82                         |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALBERT C. HERRMANN, M.D.  |  |   |  |   | 22e. ADDRESS<br>5525 BELAIR RD., BALTO. MD 21206   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>8/20/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  | 23d. LOCATION<br>IN OR TOWN COUNTY STATE<br>Balto., Balto., MD                                  |   |   |  |
| 24. FUNERAL DIRECTOR<br>John C. Miller, Inc., 6415 Belair Rd.  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 20 1982   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u> |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |  |  |   |   |   |
|--|--|--|---|--|--|--|---|---|---|
| 1. FOR STATE REGISTRAR   |  |  |   |  | 8 2 2 0 9 3 2  |  |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  |   |   |   |
| Robert L Sturdivant  |  |  |   |  | August 26 1982 09 40 M   |  |   |   |   |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR MONTHS DAYS  |   |
| MALE   |  | BLACK  |   | 12 25 02   |  | 79 YRS.  |   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |   |
| N.C.   |  | USA  |   |  |  | CITY MD  |   |   |   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| Baltimore  |  | University of Maryland Hosp  |   |  |  |  |   |   |   |
| 13a. STATE   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |   |
| Md.  |  |  |   | BALTIMORE  |  | 3617 MULBERRY ST.  |   |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |  |  |  |   |   |   |
| RICHM. J. STURDIVANT   |  | LULA HOWELL  |   |  |  |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |  |   |   |   |
| NO   |  | 213-07-9437  |   | MARY STURDIVANT (SAME)   |  |  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>2500 Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Renal Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Day</u><br><u>4 Days</u><br><u>Years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |  |  |  |   |   |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that (this hospital) attended the deceased from <u>7/31/82</u> , 19 <u>82</u> , to <u>August 26</u> , 19 <u>82</u> , that (we) lost saw the deceased alive on <u>August 26</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (we) (did) <u>not</u> view the body after death.                      |  |  |   |  |  |  |   |   |   |
| 22b. SIGNATURE <u>Wendy Kloesz</u> MD  |  |  |   |  | 22c. DATE SIGNED <u>8/26/82</u>                                  |  |   | 22d. ADDRESS <u>22 South Greene St Baltimore</u>  |   |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wendy Kloesz</u>  |  |  |   |  | 22f. ADDRESS <u>22 South Greene St Baltimore</u>                 |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  |  | 23b. DATE <u>8-31-82</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem PK Arbutus</u> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Md</u> |   |   |
| 24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H. 1101 E. North Ave</u>   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <u>AUG 27 1982</u>                 |  | 25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>  |   |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20933

|  |              |   |  |   |  |  |   |  |
|--|--------------|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Frank N. Style  |              |   | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 8 9 19 82 |   |  | 2b. HOUR<br>M 10:38<br>a.m.  |   |  |
| 3. SEX<br>M  | 4. RACE<br>W | 5. DATE OF BIRTH<br>7/30/33   | 6. AGE (IN YEARS)<br>49 YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>8 9 19 82  |   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hosp.-DOA |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>Comoduty grade |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>MD   |              |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1402 Hull St.   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Konstanty Style  |              |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Starkiewicz                    |   |  | 16. SOCIAL SECURITY NO.<br>1957-1959 219-283807                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>yes   |              |   | 16b. SOCIAL SECURITY NO.<br>1957-1959 219-283807                                     |   |  | 17. INFORMANT<br>Kathleen Style 1402 Hull St.                                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____   |              |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |              |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |              |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                    |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |              |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |              |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                          |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |              |   |  |   |  |  |   |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.  |              |   | TITLE (SPECIFY)<br>M.D. Assistant  |   |  | MEDICAL EXAMINER<br>DATE SIGNED 8-9-82   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |              |   | ADDRESS<br>111 Penn Street   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)  |              |   | 23b. DATE<br>8/12/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery                            |  | 23d. LOCATION<br>City or Town County State<br>Baltimore City Baltimore MD           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles L. Stevens   |              |   | ADDRESS<br>Funeral Home, 1501 E. Baltimore Ave.                                      |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>AUG 10 1982                                 |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5. RETURN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |   |  |  |                |   |                         |   |                          | REG. NO. 20934                               |       |                     |      |            |
|--|---------|---|--|--|----------------|---|-------------------------|---|--------------------------|--|-------|---------------------|------|------------|
| 1. FOR STATE REGISTRAR   |         | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  | MIDDLE         | LAST  | 20. DATE KNOWN OF DEATH |   | XX MONTH                 | DAY  | YEAR  | 2b. HOUR            |      |            |
|  |         | Karen M. Subocz   |  |  |                |   | 8 1 19 82               |   |                          |  |       | M                   |      |            |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  | IF UNDER 1 YR. |   | IF UNDER 24 HRS.        |   | 2c. DATE PRONOUNCED DEAD |  | MONTH | DAY                 | YEAR | 2d. HOUR   |
| F  | W       | 9/13/64   |  | 17 YRS.  |                |   |                         |   | 8 1 19 82                |  |       |                     |      | 5:50 P. M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                         |   |                          |  |       |                     |      |            |
| California   |         | USA   |  |  |                | Baltimore City, MD.   |                         |   |                          |  |       |                     |      |            |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                         | 12b. KIND OF BUSINESS OR INDUSTRY   |                          |  |       |                     |      |            |
| Baltimore  |         | University Hospital - STU   |  |  |                | Office Worker   |                         | General   |                          |  |       |                     |      |            |
| 13a. STATE   |         |   |  |  |                |   |                         |   |                          | 13b. CITY OR TOWN                            |       | 13c. STREET ADDRESS |      |            |
| California   |         |   |  |  |                |   |                         |   |                          | Santa Clara                                  |       | Milpitas            |      |            |
| 14. FATHER'S NAME  |         |   |  |  |                |   |                         |   |                          | 15. MOTHER'S MAIDEN NAME                     |       |                     |      |            |
| William Subocz   |         |   |  |  |                |   |                         |   |                          | Gloria Arabia                                |       |                     |      |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |   |  | 16b. SOCIAL SECURITY NO.   |                | 17. INFORMANT   |                         | ADDRESS   |                          |  |       |                     |      |            |
| No   |         |   |  |  |                | Lima Family Chapel, San Jose, Calif.  |                         |   |                          |  |       |                     |      |            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>8120 IMMEDIATE CAUSE (a) Multiple Injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |   |  |  |                |   |                         |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |       |                     |      |            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |  |  |                |   |                         |   |                          |  |       |                     |      |            |
| 19a. DATE OF OPERATION   |         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                |   |                         | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          |  |       |                     |      |            |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |   |  | 21b. TIME OF INJURY<br>HOUR XX MONTH DAY YEAR<br>3:30 P.M. 8 1 1982  |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver in auto/auto impact       |                         |   |                          |  |       |                     |      |            |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road  |                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Rt. 450 west of Huntwood Dr., Crofton, Anne Arundel Co., Md. |                         |   |                          |  |       |                     |      |            |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |   |  |  |                |   |                         |   |                          |  |       |                     |      |            |
| ACTUAL SIGNATURE   |         |   |  | TITLE (SPECIFY)<br>M.D. Assistant  |                |   |                         | DATE SIGNED 8-2-82  |                          |  |       |                     |      |            |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |   |  | ADDRESS  |                |   |                         |   |                          |  |       |                     |      |            |
| Hormez R. Guard, M.D.  |         |   |  | 111 Penn Street  |                |   |                         |   |                          |  |       |                     |      |            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |                | 23d. LOCATION CITY OR TOWN COUNTY   |                         | Fremont, Md.  |                          |  |       |                     |      |            |
| Removal  |         | 8/2/82  |  | Lima Family Cedar Lawn- Alameda Co.,   |                | Calif.  |                         |   |                          |  |       |                     |      |            |
| 24. FUNERAL DIRECTOR NAME  |         |   |  | 25a. DATE REC'D. BY REGISTRAR  |                |   |                         | 25b. REGISTRAR'S SIGNATURE  |                          |  |       |                     |      |            |
| Henry W. Jenkins & Sons Co.  |         |   |  | AUG - 3 1982   |                |   |                         | Thane J. [Signature]  |                          |  |       |                     |      |            |
| 4905 York Road Balto., Md. 21212   |         |   |  |  |                |   |                         |   |                          |  |       |                     |      |            |

1880

California State College

1880

1880



item 8 #4571 9/9/82 ph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 3 5

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)*Mildred Summers*2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
*Aug. 19, 1982* 7<sup>53</sup> M

3 SEX

*Female*

4 RACE

*Black*

5 DATE OF BIRTH

MONTH DAY YEAR  
*1 1 52*

6 AGE (IN YEARS LAST BIRTHDAY)

*30* YRS

MONTHS DAYS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

*North Carolina*

7b CITIZEN OF WHAT COUNTRY?

*USA*8 MARRIED ☒ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

*Cit*

MD.

10 CITY OR TOWN OF DEATH

*Balt.*11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)*Univ. of Md Hosp.*12a USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)*None*

12b KIND OF BUSINESS OR INDUSTRY

13a. STATE 13b. COUNTY 13c. CITY OR TOWN

*Maryland**Baltimore*

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

*1622 Ashburton Street*

14 FATHER'S NAME

*Curtis Summers*

15 MOTHER'S MAIDEN NAME

*Minnie Timmons*16a WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES NO OR UNKNOWN)*no*16b SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)*579 74 0781*17 INFORMANT *1226 Orren Street, N.E.**Leroy Evans-brother-*18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY.*5374*IMMEDIATE CAUSE (a) *myocardial infarction*

DUE TO, OR AS A CONSEQUENCE OF

(b) *as a result of death*

DUE TO, OR AS A CONSEQUENCE OF

(c) *None.*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from *8/19*, 19 *82*, to *8/19*, 19 *82*, that (I) (we) last saw the deceased alive on *8/19*, 19 *82*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐*8/19/82*23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)*Burial*

23b. DATE

*Aug. 26, 1982*

23c. NAME OF CEMETERY OR CREMATORY

*Harmony Memorial Park Landover, Maryland*23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR

*Stewart Funeral Home*

24b. ADDRESS

*4001 Benning Road, NE*

DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

*AUG 26 1982**John J. Conner*

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Their place receive certain papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Transfer to  
Marsh Funeral  
Home BP

DDMM - 16 50M 1/B1  
(CRA 15, 4)

Aug 1972

KS

Black 1

Female

North Carolina

Home

1000 1st Street

1000 1st Street

1000 1st Street

1000 1st Street

1000 1st Street

1000 1st Street

1000 1st Street

1000 1st Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 0 9 3 6<br>REG. NO.   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOROTHY SASSMAN</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR HOUR<br><b>Aug. 17 1982 11:47 AM</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MAY 02 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>LEVINDAVE HEBREW GERIATRIC HOSPITAL</b>         |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>APT. 18 6968 MARSUE DRIVE NW</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HYMAN</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>CHERNICK MARY UNKNOWN</b>                                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>215-74-2145</b>  |  | 17. INFORMANT <b>DONALD SASSMAN</b>   |  |   |  | 17. ADDRESS<br><b>3302 BEN VALLEY RD. BALTO., MD 21207</b>   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4360 IMMEDIATE CAUSE (a) Cerebrovascular Accident</b>   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 DAYS</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>9/3</b> , 19 <b>81</b> , to <b>8/17</b> , 19 <b>82</b> , that (we) lost the deceased alive on <b>8/17</b> , 19 <b>82</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z). |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>ESTRELLITA O. KIN, M.D.</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br><b>8/17/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br><b>LEVINDAVE HEBREW GERIATRIC HOSPITAL</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>AUG. 18, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 20 1982</b>   |  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Campbell</b>   |  |  |  |

0000 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |   |   |  |  |   | 8 2 2 0 9 3 7<br>REG. NO.  |  |   |  |                |  |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
|---|--|--|---|--|---|---|--|--|---|--|--|---|--|----------------|--|-----------------------------------|--|---|--|---|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  | 1. DECEASED NAME (TYPE OR PRINT)                                    |   |  |  |   | FIRST<br>ALBERT  |  | MIDDLE<br>SYDNOR                            |  | LAST<br>SYDNOR |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 8 14 82   |  | 2b. HOUR<br>1:25a M                     |  |  |  |  |   |  |  |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>Black  |  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 27 31  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.  |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS              |  |                | 8. IF UNDER 24 HRS. HOURS MIN.               |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |   |  |                |  |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC BALTIMORE, MARYLAND 21218 |  |   |   |  |  |   |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY   |  |   | 13c. CITY OR TOWN<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>200 N. Payson Street |  |                |  |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Willie Sydnor  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Fannie Miller         |   |  |  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes |  |   |  |                |  |                                   |  |   |  | 16b. SOCIAL SECURITY NO.<br>230 34 6530 |  |  |  |  | 17. INFORMANT ADDRESS<br>Janie Warren Halifax Co., Virginia |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>4149</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Ischemic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Congestive Heart Failure</u> |  |  |   |  |   |   |  |  |   |  |  |   |  |                |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |   |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |   |  |  |   |  |  |   |  |                |  |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                |  |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  |   |  |                |  |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                |  |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> , 19 <u>82</u> , to <u>8/13</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>8/13</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |   |  |  |   |  |  |   |  |                |  |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>J. Howell</u>  |  |  |   |  |   |   |  |  |   | DEGREE<br>MD   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                |  | 22c. DATE SIGNED<br>8/14/82       |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>J. Howell, MD.</u>  |  |  |   |  |   |   |  |  |   | 22e. ADDRESS<br><u>Loch Raven V.A. Hospital Balto, Md.</u>   |  |   |  |                |  |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  |   |  | 23b. DATE<br>8/20/82  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Millstone Cemetery |   |  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Halifax co. Va.   |                |  |                                   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><u>Wm. E. March F.H.</u>   |  |  |   |  |   |   |  |  |   | ADDRESS<br><u>1101 E. North Ave</u>  |  |   |  |                | 25a. DATE REC'D. BY REGISTRAR<br>AUG 16 1982 |                                   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Joan J. Conner</u> |  |   |  |  |  |  |   |  |  |  |  |

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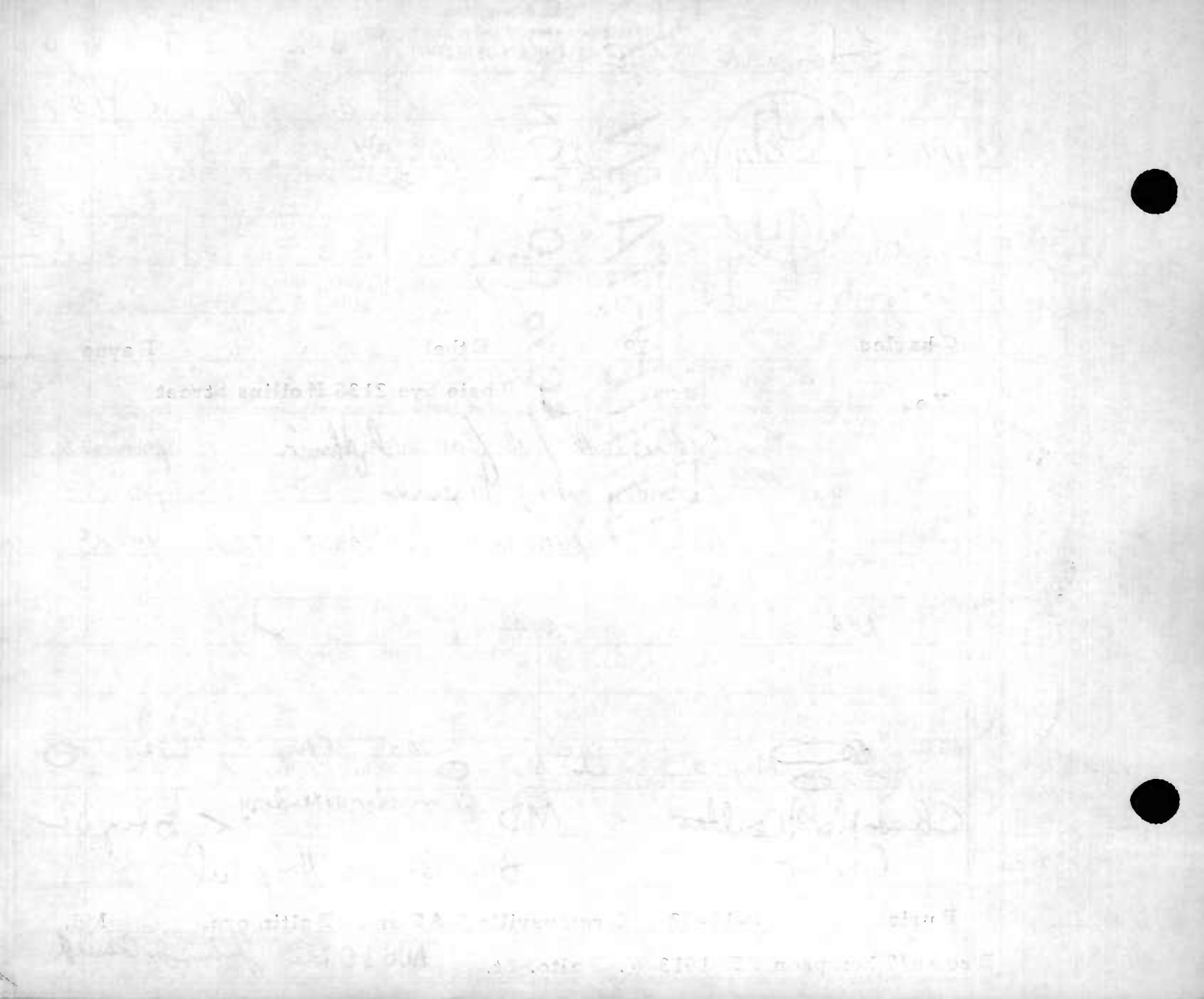
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, report any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | Howard. SYE  |  |   |  | 8 2 2 0 9 3 8  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR                                       |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 10. 10 59                                      |  |
| CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY              |  |
| Baeto   |  | Bon Secours Hosp   |  |   |  | R-J Taylor   |  | unknown  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                            |  |
| Baeto MD  |  | Baeto  |  | City  |  | YES  |  | 2138 Hollins St.                               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  |  |
| Charles Sye   |  |  |  | Ethel Payne   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |  |  |
| Yes   |  |  |  | 218-09 2667   |  | Rosie Sye 2138 Hollins Street  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sudden death - prob. from arrhythmia  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 2500  |  |  |  |   |  |  |  | few minutes                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  | years  |  |
| b. Coronary artery disease  |  |  |  |   |  |  |  | years  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  | years  |  |
| c. Diabetes, hypertension and prev. heart attack  |  |  |  |   |  |  |  | years  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |  |   |  |  |  |  |  |
| MIA   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                               |  |  |  |
| MIA   |  | MIA  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
|   |  | P.M. 19  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  |  |  |   |  |  |  |  |  |
| 22a. I certify that this hospital attended the deceased from early 19 20's, to 4 Aug 19 82, that (I/we) just saw the deceased alive on May 25 19 82, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  |  |  | 22c. DATE SIGNED                               |  |
| Christopher J. Coulter  |  |  |  | MD  |  |  |  | 5 Aug 82                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |  |  |
| Coulter   |  |  |  | Bon Secours Hospital  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| Burial  |  | 8-10-82  |  | Crownsville VACem.  |  | Baltimore, Md.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| Brown/Thompson FH 1913 W. Balto. St.  |  |  |  | AUG 10 1982 John J. Cairns  |  |  |  |  |  |



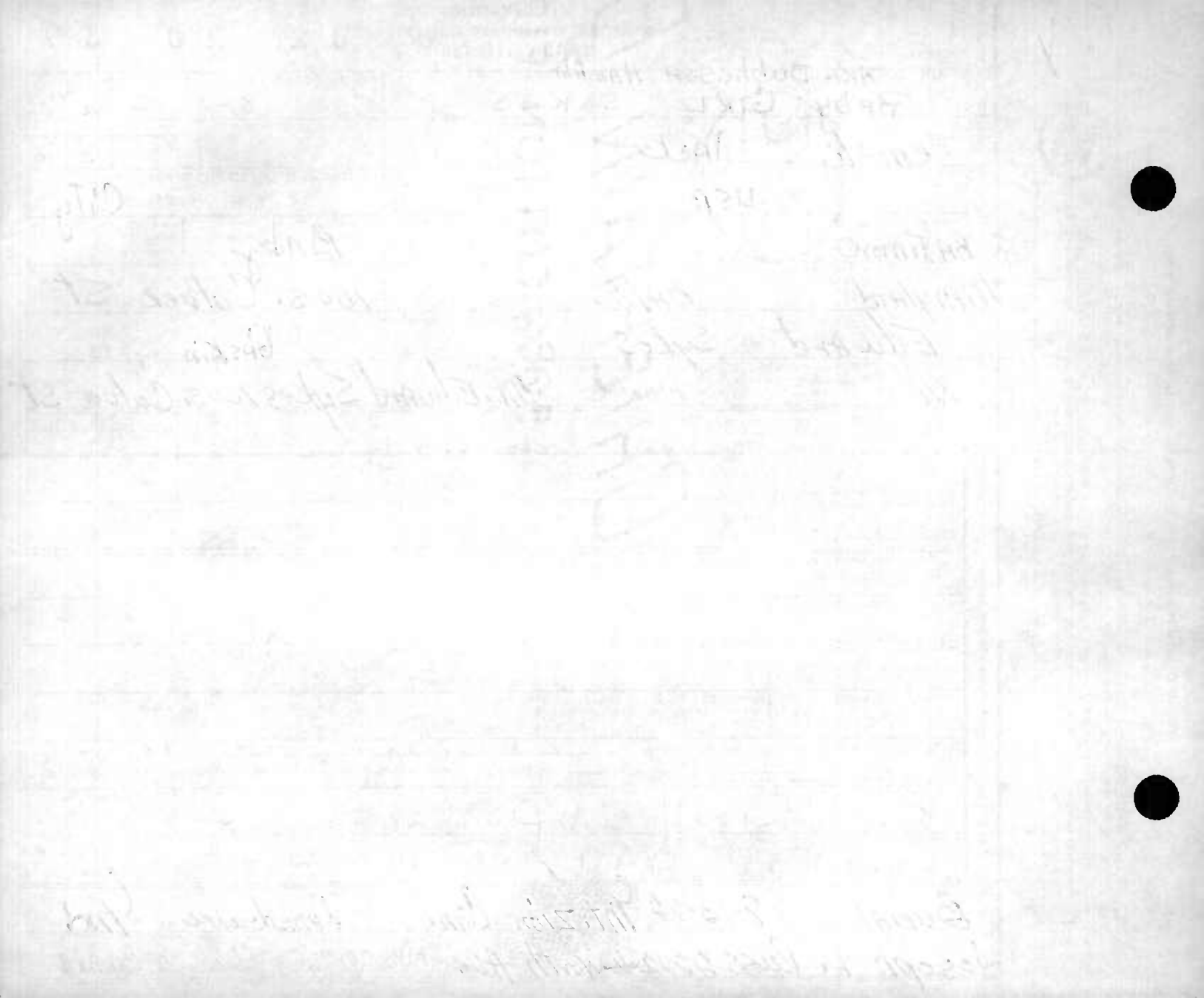


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21b shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 2 0 9 3 9   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>AKA Dubhessa Hambley Baby GIRL SYKES</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>8-8-82</b>   |  |   |  | 2b. HOUR <b>12 40 PM</b>  |  |   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 8 82</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>YRS.</b>                               |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7. BIRTHPLACE (COUNTRY) <b>Maryland.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City MD.</b>            |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BABY</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>Maryland BALTO.</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>1005 Culver St</b>                                 |  |   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Sykes</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Gaskin Sykes</b>  |  |   |  | 16. ADDRESS <b>Mr. Edward Sykes 1005 Culver St</b>                                |  |   |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  | 17b. SOCIAL SECURITY NO. <b>NONE</b>   |  | 17. INFORMANT <b>Mr. Edward Sykes</b>                                     |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>7650 Extreme Prematurity</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22a. I certify that (if this hospital) attended the deceased from <b>8-8-82</b> to <b>8-8-82</b> , that (we) last saw the deceased alive on <b>8-8-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.   |  |  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>RQ Chernoff</b>   |  |  |  | DEGREE <b>MD.</b>  |  |   |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Chernoff</b>   |  |  |  | 22e. ADDRESS <b>Univ Maryland Hst</b>  |  |   |  | 22f. <b>225 Greene St.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>   |  | 23b. DATE <b>8-13-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ansdowne Md.</b>               |  | 23e. DATE REC'D. BY REGISTRAR <b>AUG 20 1982</b>                                  |  |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph L. Russ 2222 W. North Ave</b>   |  |  |  |  |  |   |  |   |  |   |  |
| 25. REGISTRAR'S SIGNATURE <b>John J. Connel</b>   |  |  |  |  |  |   |  |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16-50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |   |   |  |                                   |  |  |
|--|--|--|--|--|---|---|--|-----------------------------------|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  | 8 2 2 0 9 4 0   |   |  |                                   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH   |   |  |                                   |  |  |
| FIRST MIDDLE LAST<br>Elizabeth A. Tankersley   |  |  |  |  | MONTH DAY YEAR HOUR<br>8 - 9 - 82 330 <sup>PM</sup>                 |   |  |                                   |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  | 7. IF UNDER 1 YEAR                |  |  |
| Female   |  | White  |  | MONTH DAY YEAR<br>1 - 10 - 46  |   | 86  |  | MONTHS DAYS HOURS MIN.            |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |  |  |
| BALTO., MD.  |  | U.S.A.   |  |  |   | BALTO. city MD.   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| BALTO. city  |  | MERCY HOSPITAL   |  |  |   | Homemaker   |  | -                                 |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS  |                                   |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>MD. --- BALTO.   |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 525 N. EAST AVE  |                                   |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |   |  |                                   |  |  |
| FIRST MIDDLE LAST<br>GEORGE J. BORG  |  |  |  |  | FIRST MIDDLE LAST<br>JOHANNA RITTER                                 |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |                                   |  |  |
| No   |  |  |  |  | 216-10-4091   |   | 525 N. East Avenue - Balto., James B. Tankersley, Jr. Md. 21224                |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |   |   |  |                                   |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |   |  |                                   |  |  |
| IMMEDIATE CAUSE (a) Cardio - respiratory arrest  |  |  |  |  |   |   |  |                                   |  |  |
| 4275   |  |  |  |  |   |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |   |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |   |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |   |   |  |                                   |  |  |
| Left Cerebral Vascular Event   |  |  |  |  |   |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost   |  |  |  |  |   |   |  |                                   |  |  |
| saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |  |                                   |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  |   | 22c. DATE SIGNED   |                                   |  |  |
| G Groleau  |  |  |  |  |   |   | 8/9/82   |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS  |   |  |                                   |  |  |
| G Groleau  |  |  |  |  | Mercy Hospital  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial   |  |  |  |  | 8/12/82   |   | Holy Redeemer Cem.   |                                   | Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |   | 25b. REGISTRAR'S SIGNATURE   |                                   |  |  |
| John E. Moran Jr.  |  |  |  |  | AUG 10 1982   |   | John J. Canine   |                                   |  |  |
| 3000 E. Baltimore St. - Baltimore, MD 21224  |  |  |  |  |   |   |  |                                   |  |  |

MEDICAL CERTIFICATION

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
Sudden

2001 177 2001 2001 3000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|--|---|---|
| FOR<br>1 - STATE REGISTRAR   |  | REG. NO. 8 2 2 0 9 4 1  |  |   |  |   |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>WALTER   |  | MIDDLE<br>S   |  | LAST<br>TASKER  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 15 82  |   |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 4 17  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.  |  | 7b. HOUR<br>1:15pm  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2663 Hafer St.   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Noah Tasker  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cora Baker   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   |  |   |   |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>7390 S. Afton Pk., Hanover, Md.<br>Mrs. Charlotte B. Chepaitis 21076   |  |   |  |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MI.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Aspiration of abdominal contents</u>     |  |   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0  |  |   |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/1, 1982, to 8/15, 1982, that (I) (we) last saw the deceased alive on 8/15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><u>R. Gonzalez MD.</u>   |  | DEGREE  |  | 22c. DATE SIGNED<br>8/15/82   |  |   |  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. GONZALEZ, MD   |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL WILKENS & CATON AVE<br>BALTIMORE, MD   |  |   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>8-18-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crest Lawn Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Marriottsville Howard Md.                         |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Schwab   |  | 3512 Frederick Arc.<br># 21229  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 23 1982  |  |   |  |   |   |

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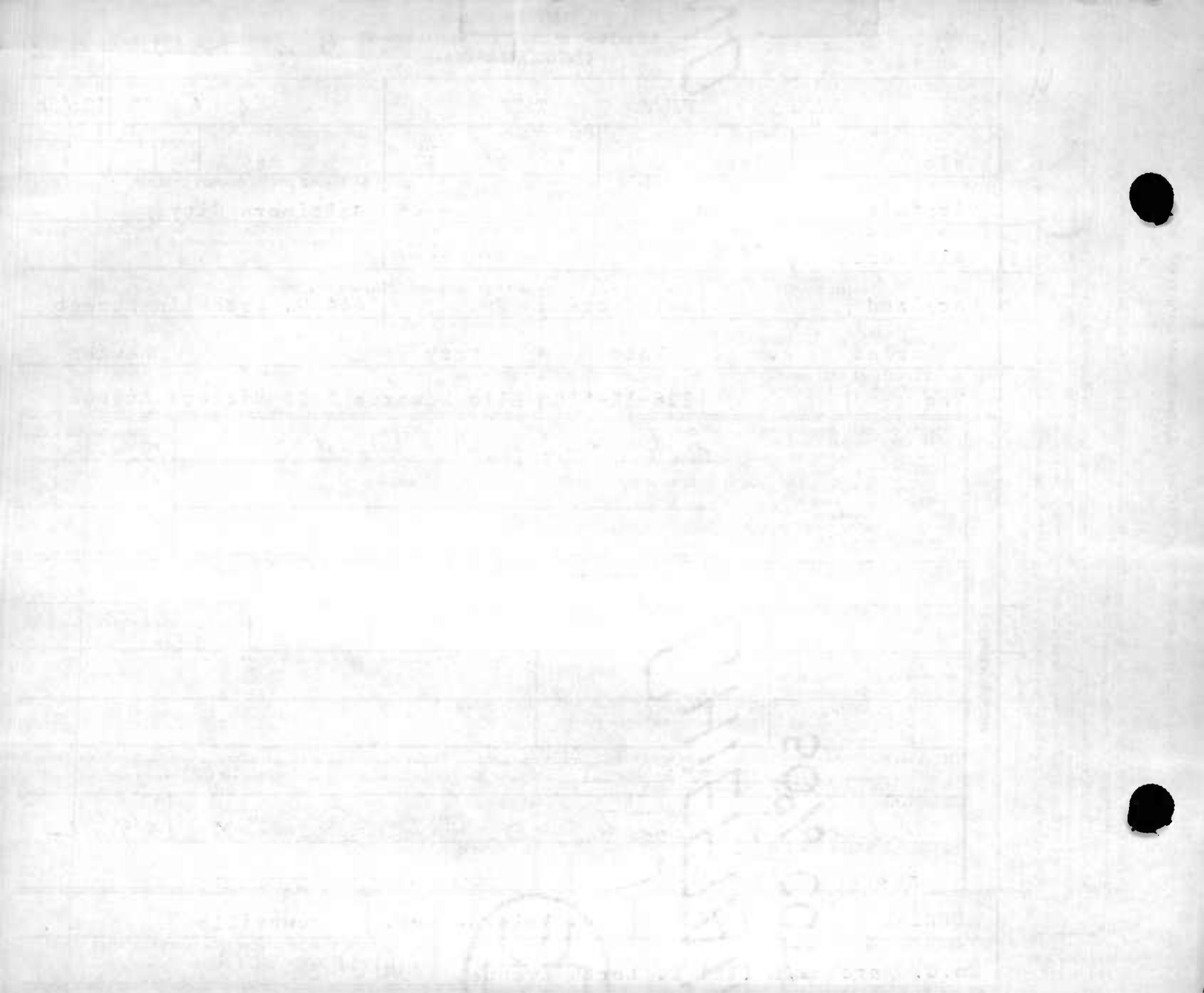
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8 2 2 0 9 4 2<br>REG. NO.  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JAMES WALKER TATE</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 4 82</b>   |  |  |  | 2b. HOUR<br><b>12:45a</b> M  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 24 13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>69</b>   |  | IF UNDER 24 HRS HOURS MIN.<br><b>69</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC 3900 LOCH RAVEN BLVD 21218</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2644 W. Franklin Street</b>  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles A. Tate</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Newton</b>  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>228-18-5106</b>  |  | 17. INFORMANT ADDRESS<br><b>Ella Edwards 3223 Vickers Avenue</b>  |  |   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4/310</b><br>IMMEDIATE CAUSE (a) <b>acute intraventricular bleed</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 hours</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 3, 19 82</b> , to <b>AUGUST 4, 19 82</b> , that (I) (we) lost <b>the deceased alive on AUGUST 4, 19 82</b> , and that in <b>(X)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (we) did not view the body after death.                         |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Rebecca Tominack MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/4/82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rebecca Tominack</b>  |  |   |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8/9/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Crownville Md.</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 06 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |  |  |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20943

1- FOR  
STATE  
REGISTRAR

|  |                  |   |  |   |   |   |
|--|------------------|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST: AMOS<br>MIDDLE: TAYLOR<br>LAST: TAYLOR   |                  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH: 8-2-82<br>DAY: 19<br>YEAR: 19 |   | 2b. HOUR<br>3:00 PM   |   |
| 3. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH: 3<br>DAY: 18<br>YEAR: 24   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY: 58 YRS.                                  | 7. IF UNDER 1 YR.<br>MONTHS: 0<br>DAYS: 0   | 8. IF UNDER 24 HRS.<br>HOURS: 0<br>MIN: 0   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tombstown S.C.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>Labour              |   |
| 13a. STATE<br>md   |                  | 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>Balto.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST: James<br>MIDDLE: Taylor<br>LAST: Taylor  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST: Sally<br>MIDDLE: Beauford<br>LAST: Beauford  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |   |   |
| 17. INFORMANT<br>Mary L Taylor   |                  | 18. SOCIAL SECURITY NO.<br>-  |  | 19. ADDRESS<br>1922 E. Madison St   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                  |   |  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |  |   |   |   |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |   |   |
| ACTUAL SIGNATURE<br>Margarita A. Korell  |                  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   | DATE SIGNED<br>8-3-82   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |                  | ADDRESS<br>111 Penn Street  |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |                  | 23b. DATE<br>8-7-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Emmanuel  |   | 23d. LOCATION<br>Tombstown S.C.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Bernell B. Oden  |                  | ADDRESS<br>Balto. Md  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG -4 1982  |   |   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

100-100000

TO THE SECRETARY OF THE ARMY  
FROM THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]

STABLE NO. 1

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 18

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 2 0 9 4 4  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| I. DECEASED NAME   |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | MONTH DAY YEAR   |  |  |  |
| Eva N.M.N TAYLOR   |  |  |  | August 14, 1982  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE   |  |
| female   |  | white  |  | MONTH DAY YEAR   |  | 7. AGE (IN YEARS LAST BIRTHDAY)                                |  |
|  |  |  |  | Nov. 17, 1892  |  | 89   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Maryland   |  | U.S.A.   |  |  |  | Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | Maryland General Hospital  |  | Housewife  |  | Home   |  |
| 13a. STATE   |  | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |
| Md.  |  | Hagerstown   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | Mt. Lena Rd Box 313  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | FIRST MIDDLE LAST  |  |  |  |
| Thomas B. Tyler  |  |  |  | Nancy Lawson   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |  |  |
| no   |  | 212-07-0971  |  | Mr. Edwin W. Taylor Hagerstown, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 7/7/82 7/19/82   |  | Left Trochanteric & Scapular Ulcers  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)  |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|  |  |  |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>June 28</u> , 19 <u>82</u> , to <u>August 14</u> , 19 <u>82</u> , that (we) (we) lost saw the deceased alive on <u>August 14</u> , 19 <u>82</u> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did) (did) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <i>Cheryl Powell M.D.</i>  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 8/15/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
| Cheryl Powell, M.D.  |  |  |  | c/o Maryland General Hospital  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial   |  | Aug 18, 82   |  | Lake View Memorial Park  |  | Sykesville Carroll   |  |
| 24. FUNERAL HOME   |  |  |  | 25a. DATE RECD. BY REGISTRAR   |  |  |  |
| Davis Funeral Home Smithsburg, Md.   |  |  |  | AUG 25 1982  |  |  |  |

MEDICAL CERTIFICATION

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner is notified by the Registrar.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 0 9 4 5   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Louis C. Tepper, Jr.</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 10, 1982</b>   |  | 2b. HOUR<br>M<br><b>A</b>  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 21, 1928</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>53</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1107 Ramblewood Road</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tool</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis C. Tepper</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emily Anderson</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mary E. Williams 1107 Ramblewood Road</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 230 24 2487</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mary E. Williams 1107 Ramblewood Road</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100</b><br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-15-79</b> , 19____, to <b>8-4-82</b> , 19____, that (I) (we) last saw the deceased alive on <b>8-4-82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                        |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Joseph Z Davids</b><br>DEGREE  |  |  |  | 22c. DATE SIGNED  |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph Z Davids MD</b>  |  |  |  | 22f. ADDRESS<br><b>5601 Loch Raven Blvd - 21239</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/13/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MITCHELL-WIEDEFELD HOME, INC.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 15 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lohr</b>  |  |
| ADDRESS<br><b>6500 York Road</b>  |  |  |  |   |  |  |  |



August 1, 1932

Miss G. Eppert, r.

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Oct. 21, 1932

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*Handwritten notes and sketches, including a small diagram of a plant or structure.*

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REPRODUCED FROM THE  
COLLECTION OF THE  
U.S. NATIONAL HERBARIUM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

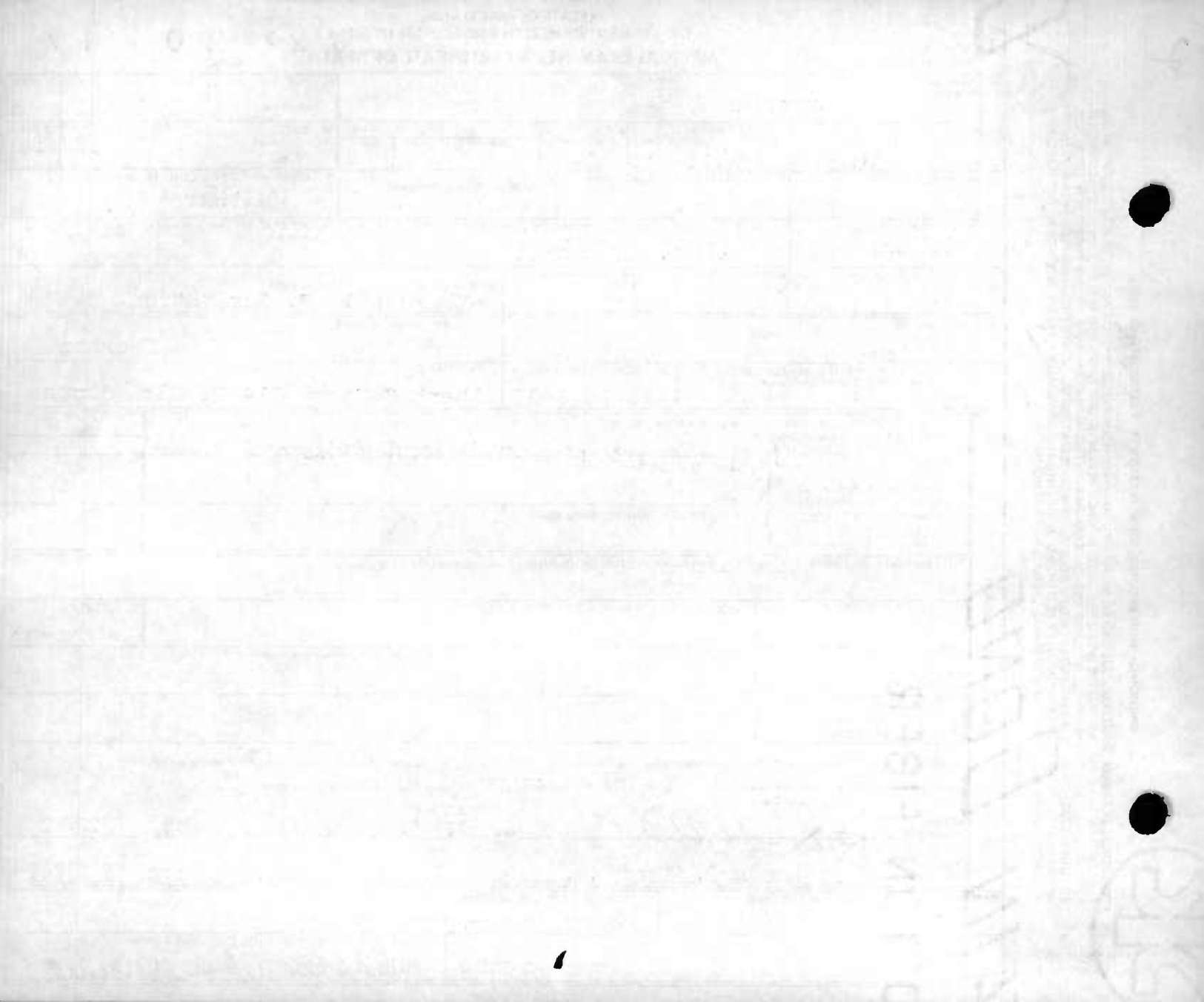
MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 0 9 4 6<br>REG. NO.   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>TIFFANY TEATS</b>  |  |  |  | MONTH <b>8</b> DAY <b>16</b> YEAR <b>82</b>   |  | 2b. HOUR <b>11</b> M   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>11</b> YEAR <b>82</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS <b>—</b> MONTHS <b>—</b> DAYS <b>5</b> HOURS <b>—</b> MIN <b>—</b>                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>—</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  |  |
| 13a. STATE <b>PA</b>  |  | 13b. CITY OR TOWN <b>MILLERSBURG</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><b>103 PARK LANE</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>SCOTT</b> MIDDLE <b>—</b> LAST <b>TEATS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>CYNTHIA</b> MIDDLE <b>LEBO</b> LAST <b>—</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  |
| 16a. SOCIAL SECURITY NO.<br><b>—</b>  |  | 17. INFORMANT<br><b>MEDICAL RECORD</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7469 IMMEDIATE CAUSE (a) CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CYANOTIC CONGENITAL HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45 MIN</b><br><b>5 DAYS</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>8/14/82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>PULMONARY ATRESIA</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. DATE SIGNED<br><b>8/16/82</b>   |  |
| 22b. SIGNATURE <b>Richard Ringer</b> DEGREE <b>—</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD RINGER, MD</b>  |  |  |  | 22d. ADDRESS<br><b>1182 Market Millersburg Pa</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>AUG 18 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HARRISBURG EAST</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HARRISBURG DAUPHIN PA</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Dale M. Hanna</b> ADDRESS <b>1182 Market Millersburg Pa</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 23 1982</b> 25b. REGISTRAR'S SIGNATURE <b>John E. Briel</b>  |  |  |  |

2000-0011

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |   |   |   |  |                                   |   |  | REG. NO. 20947                                   |  |
|--|-------------------------|---|---|---|---|--|-----------------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Catherine R. Terry</b>  |                         |   |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 20 1982</b> |                                   | 2b. HOUR <b>AM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 12 13</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>69 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.                                | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>8 20 1982</b>  |                                   | 2d. HOUR <b>8:40 AM</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                                   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>214 E. 23rd Street</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         |   |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>214 E. 23rd Street</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Dent</b>  |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Jackson</b>  |   |  |                                   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>219-18-3836</b>  |   | 17. INFORMANT<br><b>Albert S. Terry</b>   |   |  |                                   | ADDRESS<br><b>214 E. 23rd Street</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |                         |   |   |   |   |  |                                   |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |   |   |   |   |  |                                   |   |  |  |  |
| 19a. DATE OF OPERATION   |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |                                   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |                                   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                                   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |   |  |                                   |   |  |  |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b>  |                         |   |   | TITLE (SPECIFY)<br><b>Assistant</b> M.D. MEDICAL EXAMINER   |   |  |                                   | DATE SIGNED <b>8/20/82</b>  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>  |                         |   |   | ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>   |   |  |                                   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>8/24/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                       |                                   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>   |                         |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 23 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>  |                                   |   |  |  |  |



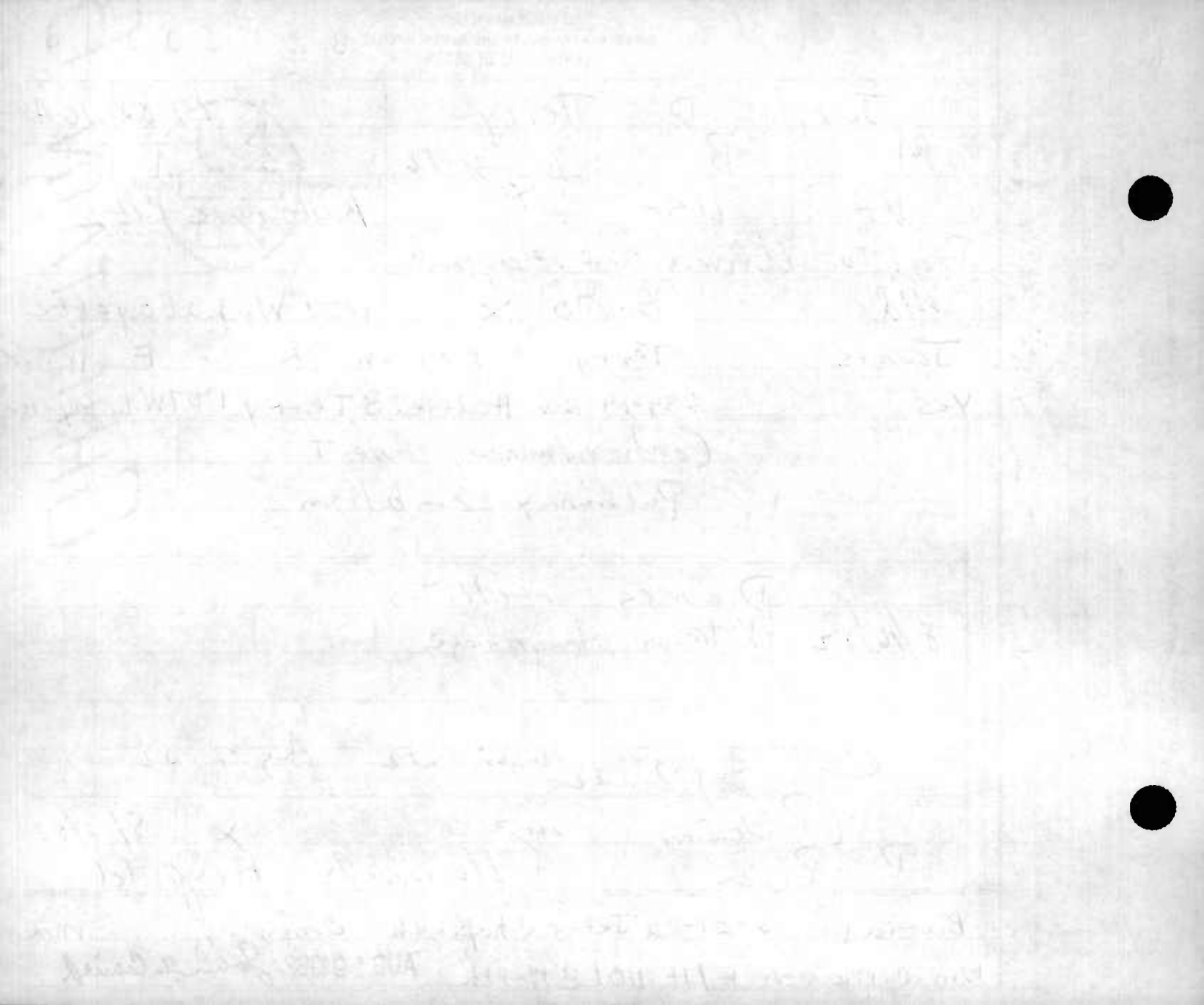
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified and the medical certificate must be completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8 2 2 0 9 4 8  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME   |  |  |  |  |  |  |  |  |  | REG. NO.   |  |
| 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 7b. HOUR   |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE  |  |
| 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE   |  |
| 7a. BIRTHPLACE   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                   |  |
| 8. MARRIED   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION        |  |
| 12a. USUAL OCCUPATION  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| 13a. STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.                                       |  |
| 17. INFORMANT  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |
| 18. CAUSE OF DEATH   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |
| (b)  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED               |  |
| 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |
| OR CONTRIBUTING  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED                                       |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY   |  |
| 21f. LOCATION  |  |  |  |  |  |  |  |  |  | 21g. LOCATION  |  |
| 22a. I certify that (I) this hospital attended the deceased from   |  |  |  |  |  |  |  |  |  | 22b. DATE SIGNED   |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. ADDRESS   |  |
| 22d. PHYSICIAN'S NAME  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |
| Joseph D Terry   |  |  |  |  |  |  |  |  |  | 8 17 82  |  |
| M  |  |  |  |  |  |  |  |  |  | B  |  |
| 10 31 16   |  |  |  |  |  |  |  |  |  | 65 YRS.  |  |
| VA.  |  |  |  |  |  |  |  |  |  | USA  |  |
| BALTO.   |  |  |  |  |  |  |  |  |  | Baltimore City MD.   |  |
| University of Maryland   |  |  |  |  |  |  |  |  |  |  |  |
| MD   |  |  |  |  |  |  |  |  |  | BALTO  |  |
| 1807 W. Lafayette  |  |  |  |  |  |  |  |  |  |  |  |
| James Terry  |  |  |  |  |  |  |  |  |  | Mariah Faulkner  |  |
| YES  |  |  |  |  |  |  |  |  |  | 239-14-7200  |  |
| Hattie S Terry   |  |  |  |  |  |  |  |  |  | 1807 W. Lafayette  |  |
| 3792   |  |  |  |  |  |  |  |  |  |  |  |
| Cardiopulmonary Arrest   |  |  |  |  |  |  |  |  |  |  |  |
| Pulmonary Embolism   |  |  |  |  |  |  |  |  |  |  |  |
| Diabetes mellitus  |  |  |  |  |  |  |  |  |  |  |  |
| 8/16/82  |  |  |  |  |  |  |  |  |  | Vitreous Hemorrhage  |  |
| 21a. ACCIDENT WAS UNDERLYING   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |
| OR CONTRIBUTING  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED                                       |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY   |  |
| 21f. LOCATION  |  |  |  |  |  |  |  |  |  | 21g. LOCATION  |  |
| 22a. I certify that (I) this hospital attended the deceased from   |  |  |  |  |  |  |  |  |  | 22b. DATE SIGNED   |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. ADDRESS   |  |
| 22d. PHYSICIAN'S NAME  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |   |  |   |  |
|--|--|--|--|---|---|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |   |  |
| REG. NO. 8 2 2 0 9 4 9   |  |  |  |   |   |   |  |   |  |
| 1. FOR STATE REGISTRAR   |  |  |  |   |   |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANCES THOMPSON</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>10</b> YEAR <b>82</b> 2b. HOUR <b>2:55AM</b>     |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>10</b> YEAR <b>95</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hosp.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br><b>2645 Beryl Avenue</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>-</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>-</b>                    |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |  | 17. INFORMANT ADDRESS<br><b>Cullen J. Cook 2645 Beryl Avenue</b>  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>5990</b> IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metabolic acidosis.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Urinary tract infection.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several days</b> |  |  |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>cerebro vascular accident, gastro intestinal bleeding,</b>  |  |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-</b>  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>8/9/82</b> , to <b>8/10/82</b> , that (we) last saw the deceased alive on <b>8/10/82</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>A. Sirithara</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   |   |  | 22c. DATE SIGNED                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. A. SIRITHARA</b>   |  |  |  |   | 22e. ADDRESS  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/14/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |  |  |   | 25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE<br><b>AUG 11 1982 John J. Conner</b> |   |  |   |  |

WASHINGTON, D. C. JANUARY 10, 1910

My dear Sir:

I have the honor to acknowledge the receipt of your letter of the 2nd inst. in relation to the matter of the proposed purchase of the land for the establishment of a new plant industry.

I am sorry to hear that you are unable to visit the land at the present time.

I have, however, been able to examine the land and find it to be well adapted for the purpose.

I am sure that you will be satisfied with the results of my examination.

I am, Sir, very respectfully,  
Your obedient servant,

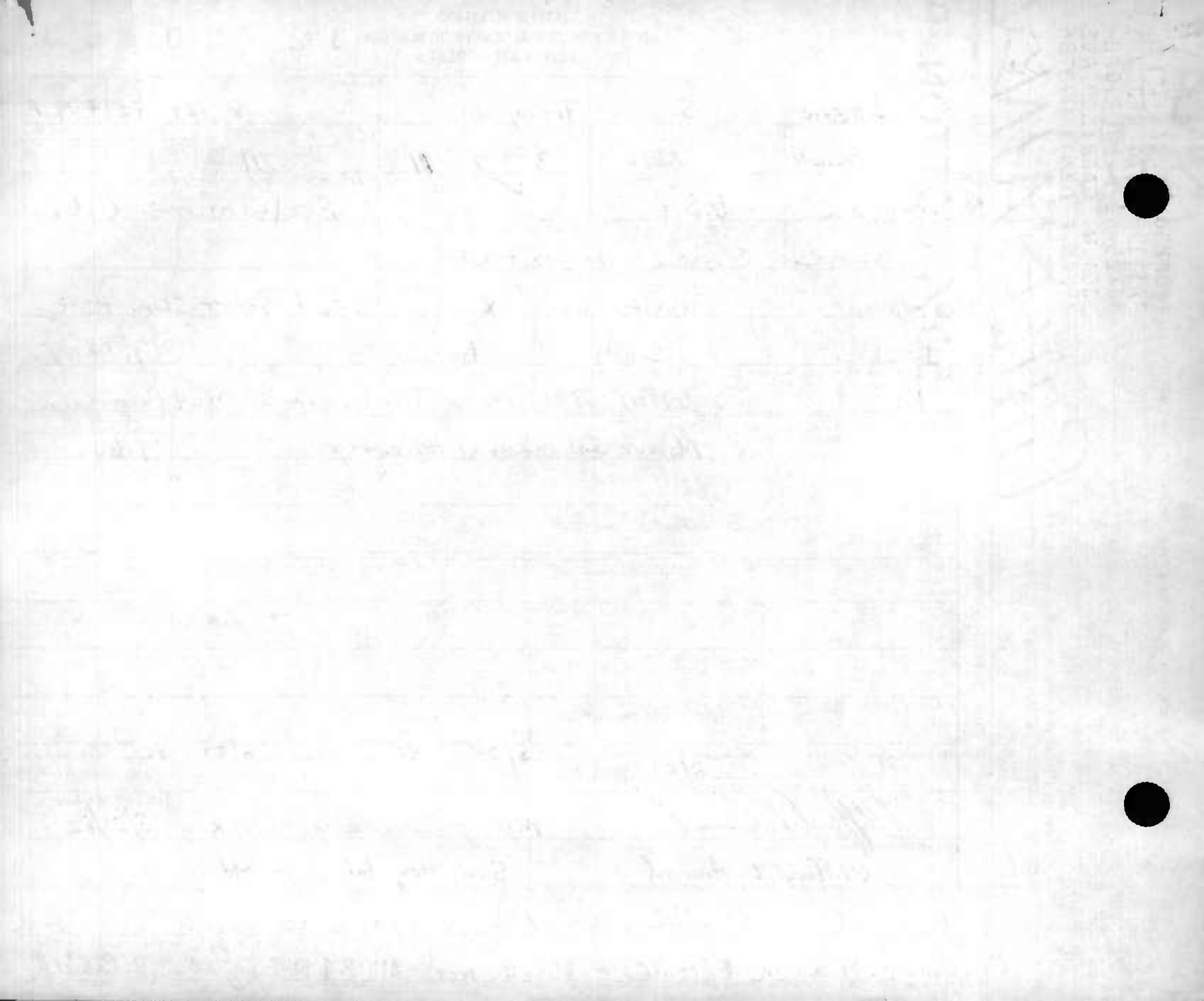
W. H. HARRIS  
Special Agent in Charge



Very truly yours,  
W. H. HARRIS

REG. NO.

|   |  |  |  |  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|-------------------------------|--|--|--|--|--|--------------------|--|------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH                         |  | DAY  |  | YEAR   |  | 2b. HOUR           |  |                  |  |  |  |
| Lozzie  |  | S.   |  | Thompson   |  |   |  | 8  |  | 29                            |  | 82   |  | 4:49   |  | P.M.               |  |                  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |                               |  | 7. IF UNDER 1 YEAR   |  |  |  | 8. IF UNDER 24 HRS |  |                  |  |  |  |
| Female  |  | Black  |  | MONTH 3 DAY 7 YEAR 11  |  |   |  | 71 YRS.  |  |                               |  | MONTHS   |  |  |  | DAYS               |  |                  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| N. Carolina   |  | USA  |  |  |  |   |  | Baltimore City MD  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |                    |  |                  |  |  |  |
| Baltimore   |  | Sinai Hospital   |  |  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| Maryland  |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2864 Garrison Ave  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | FIRST MIDDLE LAST  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| Jesse   |  |  |  | Smith  |  |   |  | Dacia McKoy  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT ADDRESS  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| No  |  |  |  | 048-18-6891  |  |   |  | John Thompson Sr. 2864 Garrison  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  |                               |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                    |  |                  |  |  |  |
| IMMEDIATE CAUSE (a) Massive Intracerebral Hemorrhage  |  |  |  |  |  |   |  |  |  |                               |  |  |  | 4 days                                       |  |                    |  |                  |  |  |  |
| 4310  |  |  |  |  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
|   |  |  |  |  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  |                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |                    |  |                  |  |  |  |
|   |  |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |                               |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |                    |  |                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
|   |  |  |  | P.M. 19  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  |  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/25 1982 to 8/29 1982, that (I) (we) last saw the deceased alive on 8/29 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |   |  |  |  |                               |  |  |  | DEGREE                                       |  |                    |  | 22c. DATE SIGNED |  |  |  |
| Clifford L. Amend   |  |  |  |  |  |   |  |  |  |                               |  |  |  | MD   |  |                    |  | 8/27/82          |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |   |  |  |  |                               |  |  |  | 22e. ADDRESS                                 |  |                    |  |                  |  |  |  |
| Clifford L. Amend   |  |  |  |  |  |   |  |  |  |                               |  |  |  | Sinai Hospital Balt. Md                      |  |                    |  |                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                               |  | 23d. LOCATION  |  |  |  |                    |  |                  |  |  |  |
| Burial  |  |  |  | 9/2/82   |  |   |  | Woodlawn Cem   |  |                               |  | Woodlawn   |  |  |  |                    |  |                  |  |  |  |
|   |  |  |  |  |  |   |  |  |  |                               |  | COUNTY STATE   |  |  |  |                    |  |                  |  |  |  |
|   |  |  |  |  |  |   |  |  |  |                               |  | MD   |  |  |  |                    |  |                  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR |  |  |  | 25b. REGISTRAR'S SIGNATURE                   |  |                    |  |                  |  |  |  |
| NAME ADDRESS  |  |  |  |  |  |   |  |  |  |                               |  |  |  |  |  |                    |  |                  |  |  |  |
| Wm. C. March F/H 1101 E. North Ave  |  |  |  |  |  |   |  |  |  | AUG 31 1982                   |  |  |  | John J. Conner                               |  |                    |  |                  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |   |  |   |   |   |   |   |  | REG. NO. 8 2 2 0 9 5 1                                    |  |   |  |  |
|--|------------------|---|--|---|---|---|---|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR   |                  |   |  |   |   |   |   |   |  |   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Minnie V. Thompson  |                  |   |  |   |   |   |   |   |  | 2a. DATE KNOWN OF DEATH<br>X MONTH DAY YEAR<br>8 27 19 82 |  | 2b. HOUR<br>M   |  |  |
| 3. SEX<br>FEMALE   | 4. RACE<br>BLACK | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 10 15  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>8 27 19 82            | 2d. HOUR<br>4:18 P. M   |   |   |  |   |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                   |   |   |  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1440 N. Bond Street |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |  |  |
| 13a. STATE<br>Md.  |                  |   |  |   |   |   |   |   |  | 13b. COUNTY<br>BALTO.                                     |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1440 N. Bond St |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANK BALL   |                  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MAGGIE SHOE BROOKS |   |   |   |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  |   |  |   | 16b. SOCIAL SECURITY NO.<br>219-10-5921                             |   | 17. INFORMANT<br>MR. ALEXANDER Thompson |   |  | ADDRESS<br>1440 N. Bond St                                |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |                  |   |  |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |   |  |   |   |   |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |                  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |   |  |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |   |  |   |  |  |
| 22a. I certify that I took charge of the remains described above; held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |   |  |   |   |   |   |   |  |   |  |   |  |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |                  |   |  | TITLE (SPECIFY)<br>M.D. Deputy Chief  |   |   |   | DATE SIGNED<br>8-28-82  |  |   |  |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |                  |   |  | ADDRESS<br>111 Penn Street  |   |   |   |   |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |                  |   |  | 23b. DATE<br>9-1-82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>KING MEM. PARK                          |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PANDALISTOWN Md.                      |  |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>REDD FUNERAL HOME - 5209 YORK RD.  |                  |   |  | ADDRESS<br>BALTO. MD.   |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 7 1982                                   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                                 |  |   |  |   |  |  |





Items 13a-e per phone 9/15/82 ddd

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH82 20952  
REG. NO.1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Baby Boy Thornton (Mother- Deborah)</b>                             |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 31, 1982</b> |   |  | 2b. HOUR<br><b>1:18 AM</b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 26 1982</b>  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>4 9 0 5</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAY<br><b>0 5</b>         |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore, Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1648 Ashburton St. 21216</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Deborah A Thornton</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  |   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |  |  |

|   |  |  |   |  |                                    |   |  |  |  |
|---|--|--|---|--|------------------------------------|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br><b>7721</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Interventricular Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Neonatal Asphyxia</b> |  |  |   |  |                                    |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Prematurity, Respiratory Distress Syndrome</b>   |  |  |   |  |                                    |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 26</b> , 19 <b>82</b> , to <b>August 31</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>August 31</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.  |  |  |   |  |                                    |   |  |  |  |
| 22b. SIGNATURE<br><b>Howard S Waxman MD</b>   |  |  |   |  |                                    | DEGREE  |  | 22c. DATE SIGNED<br><b>8/31/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Howard S Waxman MD</b>  |  |  |   |  |                                    | 22e. ADDRESS<br><b>22 South Greene St, Dept Pediatrics, Baltimore, Md 21209</b> |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>  |  |  | 23b. DATE<br><b>9/9/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Anatomy Board Balto., Md.</b>  |  |  |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 14 1982</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8 2 20953<br>REG. NO.  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                                     |  |
| FIRST MIDDLE LAST<br>HALL A. THORNTON   |  | 8 6 82 11:55 P.M.  |  |  |  |  |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 30 1897  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |  |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector   |  | 15. KIND OF BUSINESS OR INDUSTRY<br>Local Govt.  |  |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br>Maryland   |  | 16b. COUNTY<br>21239   |  | 16c. CITY OR TOWN<br>Baltimore   |  | 16d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 16e. STREET ADDRESS<br>6401 Loch Raven Blvd. |  |
| 17. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Allison Thorntons   |  | 18. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Ruddy  |  |  |  |  |  |  |  |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 19b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>183-01-9628   |  | 20. INFORMANT<br>Mary M. Walter  |  | 20a. ADDRESS<br>1700 Aberdeen Rd.  |  | 20b. 21234                                   |  |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Bronchogenic Carcinoma,<br>Pneumonia and Sepsis.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |  |  |  |  |
| 21a. DATE OF OPERATION  |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 21c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 22b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 22d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 22e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 22f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22g. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22h. SIGNATURE<br>ADEL S-EL-HEMANY  |  | 22i. DEGREE<br>M.D.  |  | 22j. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                         |  | 22k. DATE SIGNED<br>8-6-82   |  |  |  |
| 22l. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ADEL S-EL-HEMANY   |  | 22m. ADDRESS   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Aug. 10, '82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Carmel Cemetery Dunmore, Pennsylvania  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson  |  | 24a. ADDRESS<br>8521 Loch Raven Blvd.  |  | 24b. DATE REC'D. BY REGISTRAR<br>AUG 9 1982  |  | 24c. SIGNATURE<br>John J. Carver   |  |  |  |

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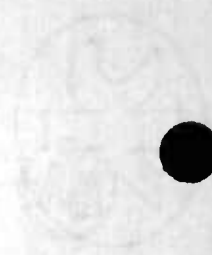
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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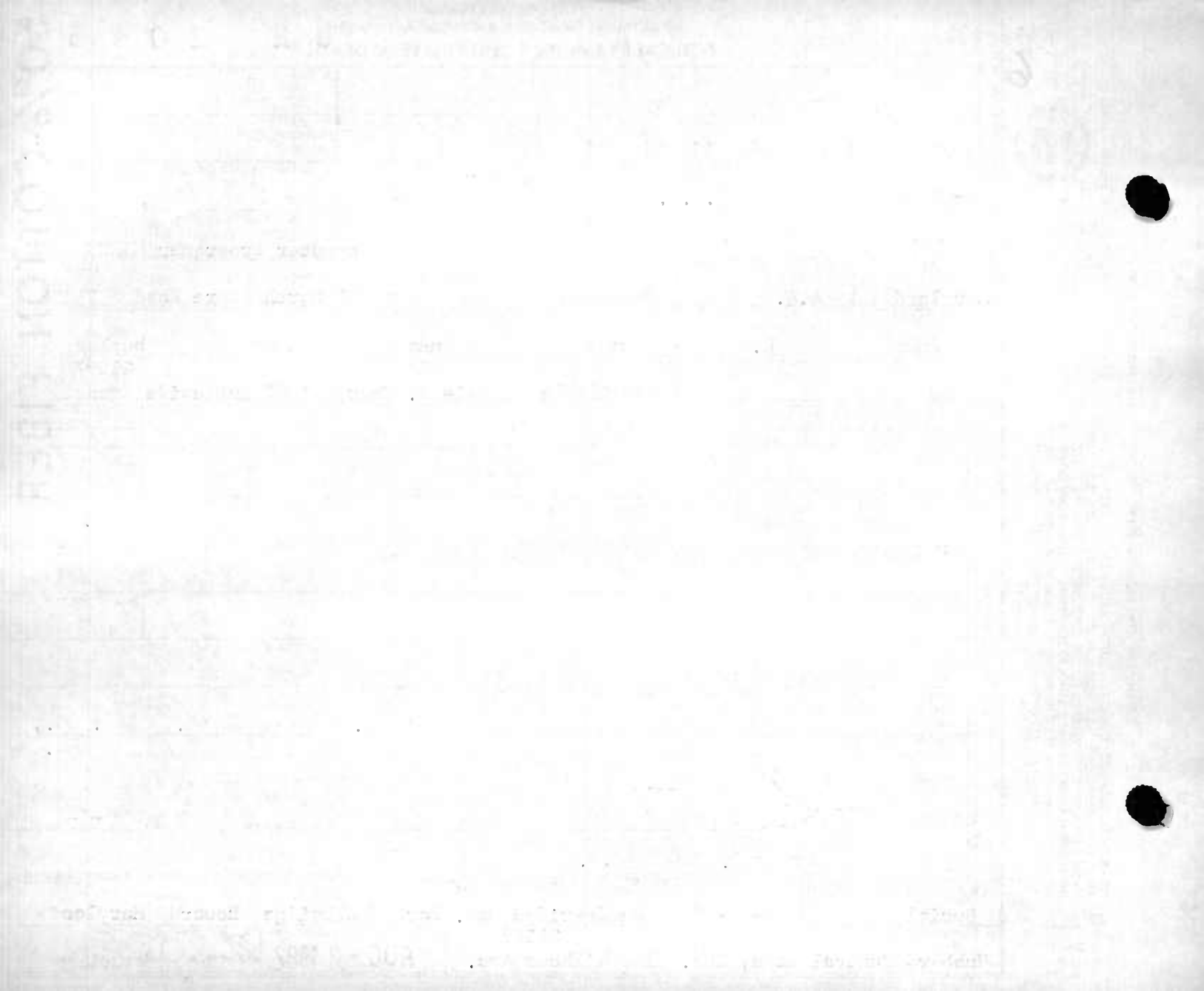
FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                  |   |   |   |  |   |   |  |                  |
|--|------------------|---|---|---|--|---|---|--|------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Anna May Thorp   |                  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>8 1 19 82 |   |  | 2b. HOUR<br>M<br>3:17 a.m.  |   |  |                  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 16 56  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>26 YRS.                       | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>8 1 19 82                     |   |  | 2d. HOUR<br>a.m. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                 |   |  |                  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital - STU |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Computer Programmer                           |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>MONTGOMERY WARD                                |  |                  |
| 13a. STATE<br>Maryland   |                  |   | 13b. COUNTY<br>A.A.   | 13c. CITY OR TOWN<br>Pasadena   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                | 13e. STREET ADDRESS<br>23 North Shore Road 21122                            |   |  |                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John R. Potts  |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Emma Backus   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No |   |  |                  |
| 16b. SOCIAL SECURITY NO.<br>Unavailable  |                  |   | 17. INFORMANT<br>Dale E. Thorp 1587 Ingleside Avenue                |   |  |   |   |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Injuries<br>8121<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |                  |   |   |   |  |   |   |  |                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |   |   |  |   |   |  |                  |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>2:15 xx 8 1 1982 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>passenger in auto/auto impact |   |   |  |                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Southwest Blvd. & Tomday Blvd., Balto. Co., Md.           |   |   |  |                  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |   |   |  |   |   |  |                  |
| ACTUAL SIGNATURE<br>Hormez R. Guard, M.D.  |                  |   | TITLE (SPECIFY)<br>M.D. Assistant                                   |   |  | DATE SIGNED<br>8-2-82   |   |  |                  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                  |   | ADDRESS<br>111 Penn Street  |   |  |   |   |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  |   | 23b. DATE<br>08-05-82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland              |  |                  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.   |                  |   | ADDRESS<br>4107 Wilkens Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG - 3 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>Name Jan Thorpe                                       |  |                  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove section papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be called.

| Item 2a., G-570 8/20/82 by F.H.D. STATE OF MARYLAND<br>Bj.   |  |  |  |   |   |  |   |   |   |  |
|--|--|--|--|---|---|--|---|---|---|--|
| 1- FOR STATE REGISTRAR<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |   |   |   |  |
| REG. NO. 82 20955  |  |  |  |   |   |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES LESTER TITHERINGTON</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 17 1982</b>                    |  | 2b. HOUR<br><b>1:38 a.m.</b>  |   |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/30/1906</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>WEST VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT CHURCH, GYM, ETC., GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL, INC.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FOREMAN</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PAPER PRODUCTS MFRG.</b>  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  |   | 13b. CITY OR TOWN<br><b>BALTO.</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13d. STREET ADDRESS<br><b>7604 PARKWOOD RD. 21222</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS J. TITHERINGTON</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET WICKER</b>         |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>232.01.3222</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>GENEVIEVE E. TITHERINGTON (WIFE) (SAME AS 13e)</b>   |   |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>5850</b> IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACIDOSIS HYPOXEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ACUTE RENAL FAILURE AND ASPIRATION</b>                              |  |  |  |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>CHRONIC RENAL FAILURE CACHEXIA CANCER OF COLON</b>  |  |  |  |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>8-17</b> , 19 <b>82</b> , to <b>8-17</b> , 19 <b>82</b> , that (2) (we) lost<br>saw the deceased alive on <b>8-17</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) did not see the body after death. |  |  |  |   |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Peter Rock</b>  |  |  |  |   | DEGREE<br><b>MD</b>   |  |   | 22c. DATE SIGNED<br><b>8-17-82</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER ROCK MD.</b>   |  |  |  |   | 22e. ADDRESS<br><b>100 North Broadway</b><br><b>Church Hospital Corporation</b> |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8/19/1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MANNINGTON MEM. PK.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MANNING WEST VIRGINIA</b>           |   |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>WALTER E. BROOKS BRADLEY, INC. DUNDALK, MD. 21222</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 18 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                  |   |   |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and signed by the attending physician. The law requires that the death certificate be executed and signed by the attending physician.

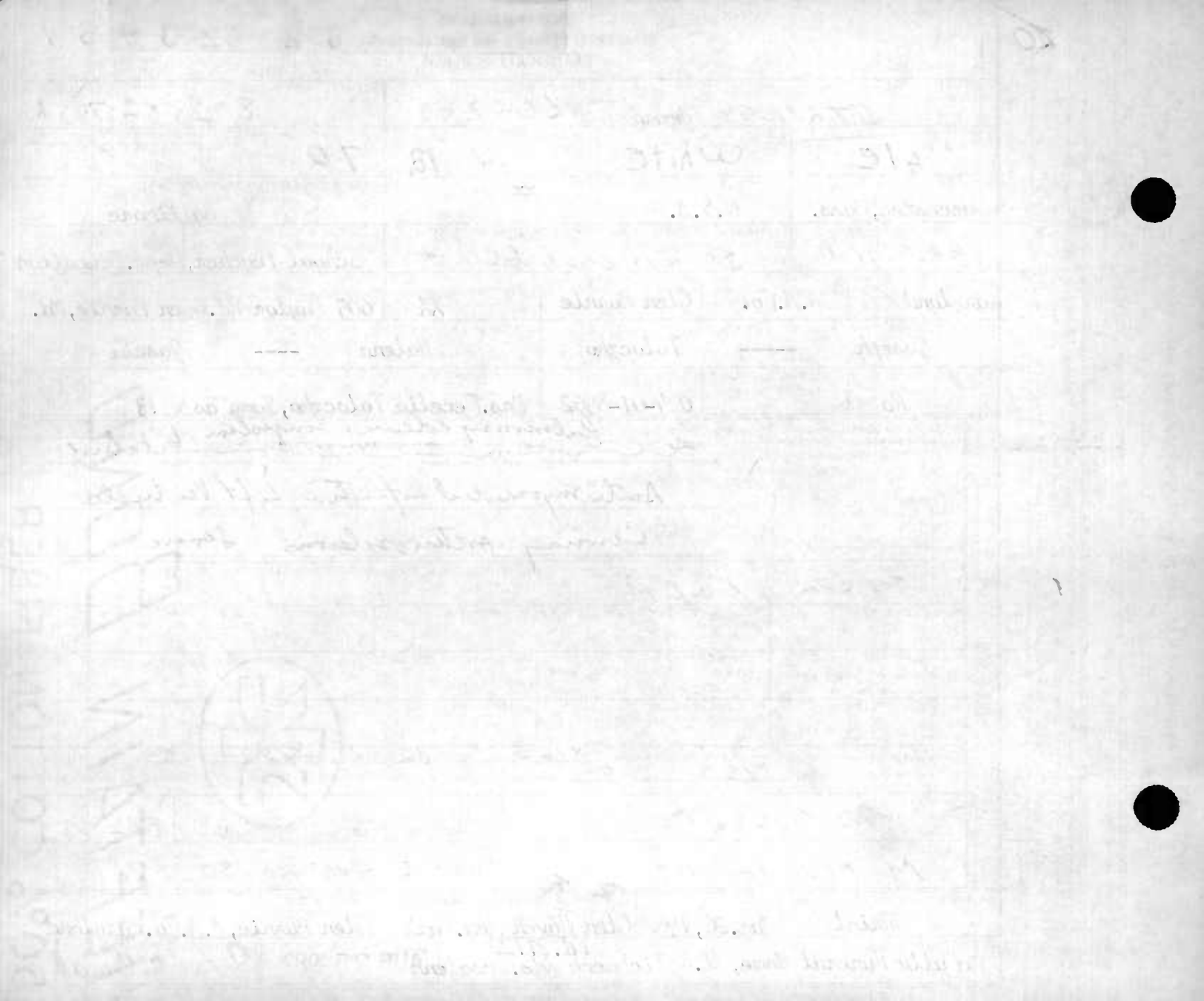
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial home permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 1B show any injury, or other traumatic event, the medical certificate must be signed by a physician.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 0 9 5 6  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>DOROTHY TOBER</b>   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>08 25 1982</b>   |  |   |  |
| 2b HOUR<br><b>09:07</b>  |  |   |  |  |  |   |  |
| 3 SEX<br><b>F</b>  |  | 4 RACE<br><b>W</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 9 1914</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN)<br>(CITY)<br><b>Baltimore</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Public Clerk</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MD.</b>   |  |   |  | 13b COUNTY<br><b>Baltimore</b>   |  | 13c CITY OR TOWN<br><b>Baltimore</b>  |  |
| 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 13e STREET ADDRESS<br><b>1437 Harbert St.</b>  |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George M. Moyer</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Schmidt</b>  |  |   |  |
| 16 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  | 16b SOCIAL SECURITY NO.<br><b>213-05-7769</b>  |  | 17 INFORMANT<br><b>Dolores Kovacs</b> 1410 Reynolds   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>possible pulmonary embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>possible sepsis.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b> |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>benign carcinoma metastatic</b>   |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION<br><b>0389</b>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>8/25/82</b> 19 <b>82</b> to <b>8/25</b> 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>8/25/82</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                |  |   |  |  |  |   |  |
| 22b SIGNATURE<br><b>Shelley E. Nolan MD</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c DATE SIGNED<br><b>8/28/82</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. NOLAN</b>  |  |   |  | 22e ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>8/28/82</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Harbortown Baltimore</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Stevens</b>   |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>AUG 30 1982</b>   |  |   |  |
| ADDRESS<br><b>Funeral Home</b>   |  |   |  | 25b REGISTRAR'S SIGNATURE<br><b>Joan J. Carver</b>   |  |   |  |





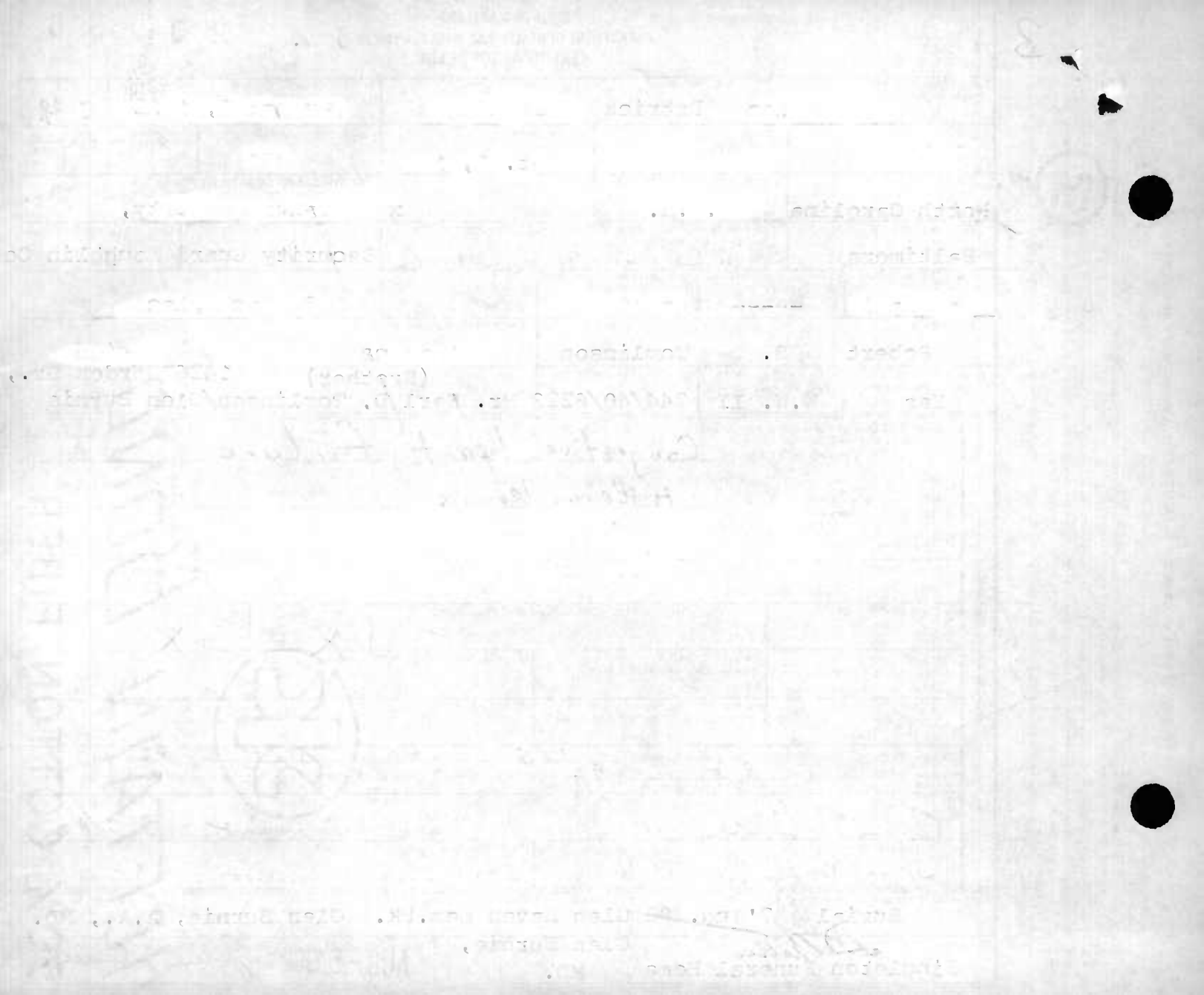


3  
1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 5 8

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Patrick Tomlinson   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>August 3, 1982                                 |  | 2b. HOUR<br>2 30 P.M.  |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 3, 1925   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Security Guard    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Loughlin Co   |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY<br>-----  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert B. Tomlinson  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Florence Quinn                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes W.W. II  |   | 16b. SOCIAL SECURITY NO.<br>244/40/6223   | 17. INFORMANT (Brother) ADDRESS 1426 Gordon Dr.,<br>Mr. Earl D. Tomlinson/Glen Burnie |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive heart failure<br>4409<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/3, 1982, to 8/3, 1982, that (I) (we) last saw the deceased alive on 8/3, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br>James F. Heiser, M.D.  |   | DEGREE  |   | 22c. DATE SIGNED<br>8/3/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James T. Heiser, M.D.   |   | 22e. ADDRESS<br>3001 South Hanover St   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>7 Aug. 82  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk.                             |  | 23d. LOCATION<br>Glen Burnie, A.A., MD.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home   |   | ADDRESS<br>MD.  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG - 5 1982  |  |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine   |  |





1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 5 9

REG. NO.

|  |  |  |   |  |                            |  |
|--|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>KENNETH TOWNS Sr.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 23, 1982</b> |  | 2b. HOUR<br><b>11:02AM</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Blak</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 15 35</b>                                 |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46 YRS.</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>46</b>   |   | 8. IF UNDER 74 HRS.<br>HOURS MIN.<br><b>11:02</b>                                    |                            |  |
| 9a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Norman Towns</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy Norris</b>   |   | 16. STREET ADDRESS<br><b>430 E. Biddle St.</b>                                       |                            |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 17b. SOCIAL SECURITY NO.<br><b>219-30-6313</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Lucy Towns 430 E. Biddle Street</b>                   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4275 Cardiac arrest</b><br>IMMEDIATE CAUSE (a) }<br>DUE TO, OR AS A CONSEQUENCE OF }<br>Conditions, if any, which }<br>gave rise to immediate }<br>cause (a), stating the }<br>underlying cause last. }<br>(b) }<br>DUE TO, OR AS A CONSEQUENCE OF }<br>(c) } |  |  |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Chronic Renal Failure</b>   |  |  |   |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Johns Hopkins Hospital</b>   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/23/82</b> , 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on <b>8/23/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                           |  |  |   |  |                            |  |
| 22b. SIGNATURE<br><b>Robert L. Redner MD</b>   |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>8/23/82</b>   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert L. Redner</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8/27/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>                              |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>   |   |  |                            |  |

RELEASED AS NON MEDICAL BY DR KENNETH TOWNS

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completely filled in by the funeral director. It should be detached for use as the burial transcript. This certificate is valid for use in Maryland only. It is not valid for use in other states. (IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.)



U

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20960

|  |  |                |                  |  |  |   |  |   |               |   |  |  |  |                                   |  |                                      |  |                          |  |  |  |  |  |
|--|--|----------------|------------------|--|--|---|--|---|---------------|---|--|--|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                | FIRST<br>WILLIAM |  |  | MIDDLE<br>TOYER   |  |   | LAST<br>TOYER |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 2 19 82              |  |                                   | 2b. HOUR<br>M 6:35                           |                                      |  |                          |  |  |  |  |  |
| 1. SEX<br>M  |  | 4. RACE<br>Bik |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR 10-29-22  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) 59 YRS.                  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |               | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 8 2 19 82   |  |                                   | 2d. HOUR<br>a M                              |                                      |  |                          |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |  |                |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br>2805 Baker St. |  |   |  |   |               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                                      |  |                          |  |  |  |  |  |
| 13a. STATE<br>Md   |  |                |                  | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN<br>Balto  |               |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  |                                   |  | 13e. STREET ADDRESS<br>2805 Baker St |  |                          |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hall Toyer   |  |                |                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth  |  |   |               |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes- WWII |  |                                   |  |                                      |  | 16b. SOCIAL SECURITY NO. |  |  |  |  |  |
| 17. INFORMANT<br>Louise Toyer  |  |                |                  |  |  | ADDRESS<br>2805 Baker St                                    |  |   |               |   |  |  |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma<br>1991<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)   |  |                |                  |  |  |   |  |   |               |   |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                      |  |                          |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                |                  |  |  |   |  |   |               |   |  |  |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |               |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                |                  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |               |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                  |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                |                  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |   |               |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                |                  |  |  |   |  |   |               |   |  |  |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.   |  |                |                  |  |  | TITLE (SPECIFY)<br>M.D. Assistant                           |  |   |               |   |  | MEDICAL EXAMINER<br>DATE SIGNED 8-5-82   |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                |                  |  |  | ADDRESS<br>111 Penn St., Balto., Md. 21201                  |  |   |               |   |  |  |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                |                  |  |  | 23b. DATE<br>8-6-82   |  |   |               |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cheltenham Nat'l   |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Cheltenham  |  |                |                  |  |  | COUNTY<br>Md  |  |   |               |   |  | STATE  |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Vernon R. Bailey   |  |                |                  |  |  | ADDRESS<br>1348 N. Calhoun St                               |  |   |               |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 06 1982   |  |                                   |  |                                      |  |                          |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Canine   |  |                |                  |  |  |   |  |   |               |   |  |  |  |                                   |  |                                      |  |                          |  |  |  |  |  |

POX CONTROL 2008

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 as any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 7 2 2 0 9 6 1   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BERTIE E. TRAIL</b>  |  |  |  |  |  |  |  |  |  | MONTH  |  | DAY  |  | YEAR   |  | 2b. HOUR  |  |  |  |
| 3. SEX <b>F</b>   |  |  |  |  |  |  |  |  |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>04 02 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b> |  |  |  |  |  |   |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>   |  |  |  |  |  |   |  |  |  |
| 13a. STATE <b>MARYLAND</b>  |  |  |  |  |  |  |  |  |  | 13b. COUNTY <b>BALTIMORE</b>   |  | 13c. CITY OR TOWN <b>ARBUTUS</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>936 CIRCLE DRIVE, 21229</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN E. TRAIL</b>   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ELLEN THRIFT</b>  |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>218-42-9171</b>  |  | 17. INFORMANT ADDRESS <b>HERBERT C. TRAIL, 938 CIRCLE DRIVE, 21229</b>   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS (EXTENSIVE CA. METASTASIS)</b> 1990   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  |  |  |  |  |   |  |  |  |
|   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS <b>CONTRIBUTING TO DEATH</b> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/2</b> , 19 <b>82</b> , to <b>8/25</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8/25</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>R. Gonzalez MD.</b> DEGREE  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED <b>8/25/82</b>  |  |  |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROLANDO GONZALEZ, MD</b>   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  |  |  |  |  |  |  |  | 23b. DATE <b>08-28-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GRANITE PRES. CH. CEM.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>GRANITE BALTIMORE MD.</b>                      |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS <b>4107 WILKENS AVE.</b>  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>   |  |  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- STATE REGISTRAR  |  |  |  | 2- DATE OF DEATH   |  |                                      |  | 3- HOUR  |  |  |  |
|---|--|--|--|--|--|--------------------------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |                                      |  | 2b. HOUR   |  |  |  |
| EDITH L. TRENT  |  |  |  | 8 13 82  |  |                                      |  | 8 13 AM  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | 7. IF UNDER 1 YEAR   |  | 7. IF UNDER 24 HRS.  |  |
| Female  |  | Negro  |  | 9 30 1918  |  | 63                                   |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 10. BALTIMORE CITY   |  | 10. MD.  |  |
| South Carolina  |  | USA  |  |  |  |                                      |  |  |  |  |  |
| 11. CITY OR TOWN OF DEATH   |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 13b. KIND OF BUSINESS OR INDUSTRY    |  |  |  |  |  |
| BALTIMORE   |  | UNION MEMORIAL HOSPITAL  |  |  |  |                                      |  |  |  |  |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 15. INSIDE CITY LIMITS?  |  |                                      |  | 16. STREET ADDRESS   |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  |                                      |  | 13c. CITY OR TOWN  |  |  |  |
| Maryland  |  |  |  | Baltimore  |  |                                      |  | 2120 N. Calvert Street   |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |                                      |  |  |  |  |  |
| Herbert Trent   |  |  |  | Mamie Robinson   |  |                                      |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |                                      |  | 17. INFORMANT  |  |  |  |
| No  |  |  |  | N/A  |  |                                      |  | Evelyn Moses 1708 Alhambra Ave.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  | 19. PART I. DEATH WAS CAUSED BY  |  |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |  |  |
| 4310  |  |  |  | IMMEDIATE CAUSE (a) Intracranial Bleed   |  |                                      |  | 8 days   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  | (b) Hypertension   |  |                                      |  |  |  |  |  |
|   |  |  |  | (c)  |  |                                      |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |                                      |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                      |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  |                                      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR (A.M.) MONTH DAY YEAR   |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
|   |  |  |  | 8:13 P.M. 8 13 1982  |  |                                      |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                                      |  | 21f. LOCATION  |  |  |  |
|   |  |  |  |  |  |                                      |  | CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/4/82, to 8/13, 1982, that (I) (we) lost the deceased on 8/13, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |                                      |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |                                      |  | 22c. DATE SIGNED   |  |  |  |
| Robert Tano MD  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |                                      |  | 8/13/82  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |                                      |  |  |  |  |  |
| ROBERT TANO, M.D.   |  |  |  | UNION MEMORIAL HOSPITAL  |  |                                      |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |  |  |
| Burial  |  |  |  | 8/18/82  |  | Arbutus Mem. Pk                      |  | Arbutus, Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |                                      |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Wm. C. March Funeral Home Inc./1101 E. North Ave  |  |  |  | AUG 16 1982  |  |                                      |  | John J. Canine   |  |  |  |



100% COTTON LABEL

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Handwritten text at the bottom left corner, possibly a signature or date.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 0 9 6 3  
REG. NO.

|   |  |   |   |   |   |  |  |   |  |
|---|--|---|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Eddie Tucker</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 31, 1982</b>   |   |   | 2b. HOUR<br><b>6:45p</b> M   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 3 18</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>Balto.</b>                                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1220 Argyle Avenue</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Dave Tucker</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susanna</b> |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>245-05-3529</b>                  |   | 17. INFORMANT<br>ADDRESS<br><b>Ruth Tucker 540 W. 146th St, N.Y, N.Y.</b>                       |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE <b>Caclexia, Dehydration and Probable Sepsis</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Status Post Partial Small Bowel</b><br>(b) <b>Infarct with Partial Resection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Artery Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3/26/82</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Chronic Obstructive Pulmonary Disease</b>  |  |   |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>August 29</b> , 19 <b>82</b> , to <b>August 31</b> , 19 <b>82</b> , that (X) (we) last saw the deceased alive on <b>August 31</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do) (not) view the body after death.  |  |   |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Jim-Jer Hwu M.D.</b>   |  |   |   |   |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>8/31/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jim-Jer Hwu, M.D.</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>                                 |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9/5/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lillington, N.C.</b>                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |  |   |   |   |   | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 3 1982</b>  |  |
|   |  |   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                  |  |   |  |

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J. D. and J. D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 13 Phone 9-3-82cn   |  | STATE OF MARYLAND  |             | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                     | 8 2 2 0 9 6 4   |  |
|--|--|--|-------------|--|---------------------|---|--|
| 1. FOR STATE REGISTRAR   |  | CERTIFICATE OF DEATH   |             | REG. NO.   |                     |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |             | 2a. DATE OF DEATH MONTH DAY YEAR   |                     | 2b. HOUR  |  |
| PRESTON  |  | TUCKER   |             | 8 28 82  |                     | 1132 PM   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |             | 6. AGE (IN YEARS LAST BIRTHDAY)  |                     | IF UNDER 1 YEAR IF UNDER 24 HRS.  |  |
| MALE   | CAUC   | 11/10/04   |             | 77 YRS   |                     | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |             | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                     |   |  |
| Unknown  | USA  |  |             | Baltimore City MD  |                     |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                     | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore  | Univ. of Md. Hosp.   |  |             | CANCER   |                     | Unk   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. STATE   | 13c. COUNTY | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS |   |  |
| Baltimore MD   |  | USA  | BALTO.      | 600 N. Paca Street   |                     |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |             |  |                     |   |  |
|  |  |  |             |  |                     |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |             | 17. INFORMANT ADDRESS  |                     |   |  |
| NO   |  | 44-01-9627   |             | ER Entry Chart Old Bond  |                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |             |  |                     |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |             |  |                     |   |  |
| IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION   |  |  |             |  |                     |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |             |  |                     |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) CORD & RESP. COMPROMISE YEARS   |  |  |             |  |                     |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) DIGITALIS TOXICITY, DEHYDRATION WEEKS.  |  |  |             |  |                     |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0   |  |  |             |  |                     |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |             | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| NA   |  | NA   |             |  |                     |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                     |   |  |
|  |  | P.M. 19  |             |  |                     |   |  |
| 21d. INJURY OCCURRED: WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                     |   |  |
|  |  |  |             |  |                     |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/27/82 19 82 to 8/28 19 82 that (I) (we) last saw the deceased alive on 8/28/82 19 82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |             |  |                     |   |  |
| 22b. SIGNATURE   |  | DEGREE   |             | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                     | 22c. DATE SIGNED  |  |
| Constantine E Gean MD  |  | MD   |             |  |                     | 8/28/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |             |  |                     |   |  |
| CONSTANTINE E GEAN   |  | Univ. Md. Hosp. Balt. MD   |             |  |                     |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |             | 23c. NAME OF CEMETERY OR CREMATORY   |                     | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| BURIAL   |  | 8/31/82  |             | LORRAINE PK  |                     | BALTO, MD   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |             | 25a. DATE REC'D. BY REGISTRAR  |                     | 25b. REGISTRAR'S SIGNATURE  |  |
| Paul E. Chomovetz  |  | 3617 Chantilly Ave   |             | AUG 31 1982  |                     | John J. G. G. G.  |  |

1910

600 N. 1st Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  |               |
|--|--|---|--|--|--|--|--|--|--|---------------|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 8 2 2 0 9 6 5  |  |  |  |  |  |  |  |               |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><i>Gaetana</i>   |  | MIDDLE<br><i>Turminello</i>  |  | LAST<br><i>Turminello</i>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>8-21-82</i>  |  | 2b. HOUR<br>M |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>White</i>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6-19-1895</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>87</i>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.  |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Sicily</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD  |  |  |  |               |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Hamilton Nursing Home</i> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>House of Worsted</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Retired</i>  |  |               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><i>503 S. Bradford Street</i>   |  |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Castore</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Concetta Tumineello</i>   |  |  |  |  |  |  |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>215-10-8653</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Frank Tumineello - 6614 Myer Ave. - 21206</i>  |  |  |  |  |  |               |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Heart failure, ASCVD and</i><br><i>1541</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>chronic arricular fibrillation</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Carcinoma of rectum</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 years</i> |  |   |  |  |  |  |  |  |  |               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |  |               |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |               |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>8/12</i> 19 <i>80</i> , to <i>8/21</i> 19 <i>82</i> , that (I) (the) lost saw the deceased alive on <i>8/12</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |  |  |  |  |  |  |  |               |
| 22b. SIGNATURE<br><i>John G. W. Fromm, MD</i>  |  | DEGREE<br><i>MD</i>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>8/23/82</i>   |  |               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>John G. W. FROMM, MD</i>   |  | 22e. ADDRESS<br><i>8014 Old Harford Rd Balto Md.</i>  |  |  |  |  |  |  |  |               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>8-24-82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer Cemetery</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>  |  |  |  |               |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John C. Miller Inc. 6415 Belair Rd. - 21206</i>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>AUG 25 1982</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>  |  |               |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | Item 5, 6, Item 16b, -Film G574,   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 8 2 2 0 9 6 6   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  |
| Benjamin  |  | TUNSTALL   |  |  |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male  |  | B  |  | 1907   |  | 76 75 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Chase City Va.  |  | U.S.A.   |  |  |  | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTIMORE   |  | John L. Denton   |  | RETIRED  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| MARYLAND  |  |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. 215-09-4740  |  |
| ALANER TUNSTALL   |  | EMMA B. WARDER   |  | NO   |  | 215-09-4740   |  |
| 17. INFORMANT   |  | ADDRESS  |  | 17. INFORMANT  |  | ADDRESS   |  |
| MRS. CLARA A. GRAVES  |  | 2200 PENROSE AVE   |  | MRS. CLARA A. GRAVES   |  | 2200 PENROSE AVE  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| 4292  |  | Acute & Chronic renal failure  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (b) Nephrosclerosis  |  |  |  |   |  |
|   |  | (c) ASCVD  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|   |  | P.M. 19  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 15, 1982 to Aug 23, 1982, that (I) (we) last saw the deceased alive on Aug 23, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |
| Julian W. Reed M.D.   |  |  |  |  |  | 8/23/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE   |  |
| JULIAN W. REED M.D.   |  | 611 S. CHAS. ST. BALTO. MD. 21238  |  | Burial   |  | 8-26-82   |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | 23e. DATE REC'D. BY REGISTRAR  |  | 23f. REGISTRAR'S SIGNATURE  |  |
| ARBUTUS MEMORIAL  |  | ARBUTUS BAYVIEW CO. MD.  |  | AUG 25 1982  |  | John J. Canich  |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| JOSEPH L. ROSS  |  | 3222 W. NORTH AVE  |  | AUG 25 1982  |  | John J. Canich  |  |



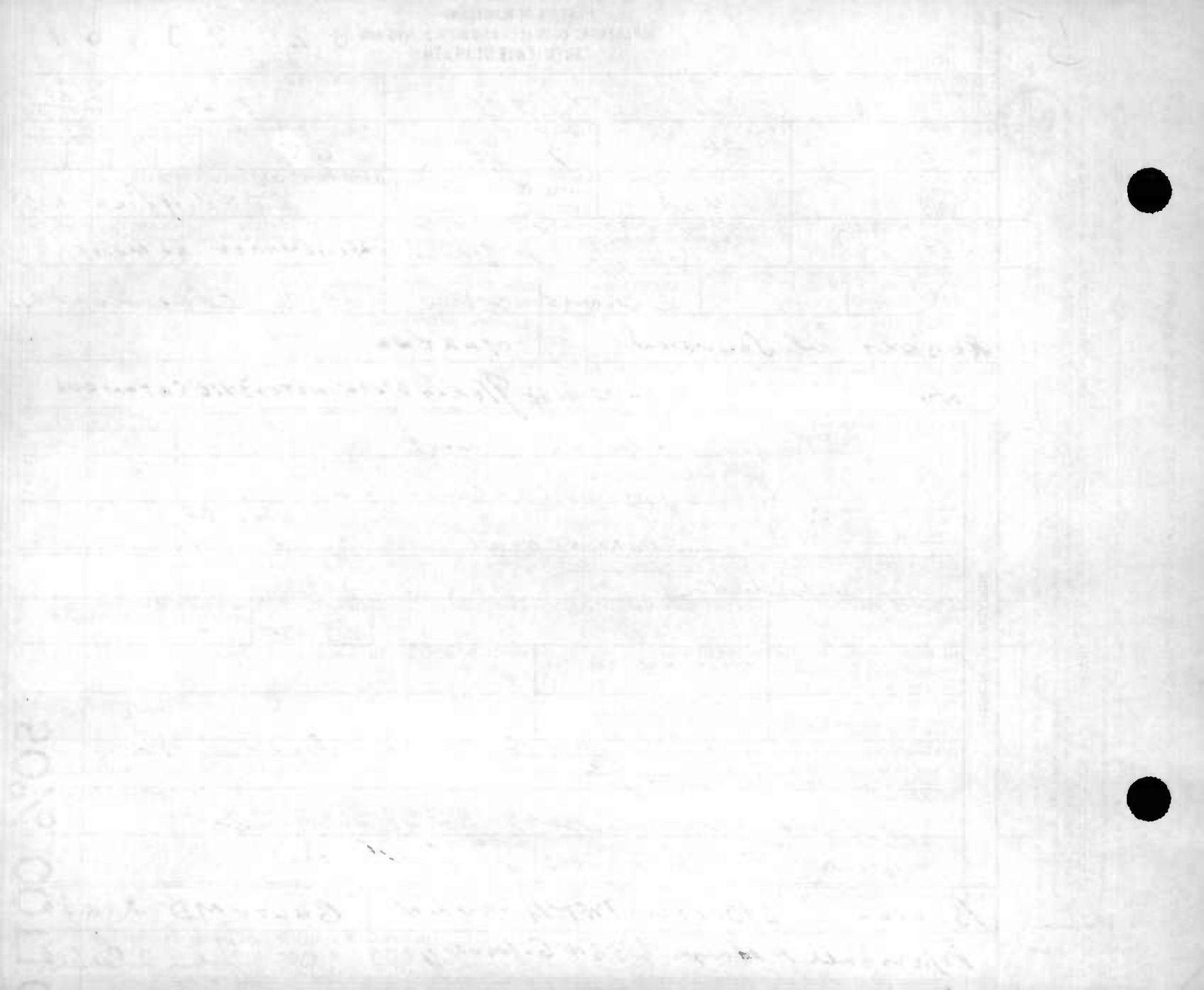
*[Faint, illegible handwriting on lined paper]*

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 2 0 9 6 7  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Ruby</i> <i>Tunstall</i>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 8 26 82   |  |   |  |
| 3. SEX <i>F</i>   |  | 4. RACE <i>B</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR 7 29 18  |  | 2b. HOUR 2 50 PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 6. AGE (IN YEARS 1ST BIRTHDAY) 64 YRS.  |  |
| 10. CITY OR TOWN OF DEATH <i>Belt RD</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University of Maryland</i> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>CITY of Baltimore MD</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>  |  |
| 13a. STATE <i>MD</i>  |  |  |  | 13b. COUNTY <i>Baltimore</i>   |  | 13c. CITY OR TOWN <i>Baltimore</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>ROBERT W. JOHNSON</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY ANN</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>   |  |  |  | 16b. SOCIAL SECURITY NO. <i>212-324088</i>   |  | 17. INFORMANT ADDRESS <i>1102 in Washington 3416 CATON AVE</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiac arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia - septicaemia</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>esophago-bronchial fist - of esoph</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>malnutrition</i> |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 16</i> , 19 <i>82</i> , to <i>Aug 26</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>Aug 26</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <i>Wayne E. Gaines MD</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  | 22c. DATE SIGNED   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wayne E. Gaines MD</i>   |  |  |  | 22e. ADDRESS <i>Un of MD Hosp</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (RECEIPT) <i>Burial</i>   |  | 23b. DATE <i>8/30/82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn</i>  |  | 23d. LOCATION (CITY OR TOWN) COUNTY <i>Baltimore MD</i>   |  |
| 24. FUNERAL DIRECTOR <i>Marshall &amp; Son</i> ADDRESS <i>635 N. Gilmor</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>SEP 1 1982</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20968

1. FOR  
STATE  
REGISTRAR

|  |              |  |  |  |   |  |   |  |
|--|--------------|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Anna (Annie) Turner   |              |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 8 21 1982 |  |   | 2d. HOUR<br>M  |   |  |
| 3. SEX<br>F  | 4. RACE<br>B | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 10 11  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 7c. DATE PRONOUNCED DEAD<br>8 23 1982   | 2d. HOUR<br>3p M   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1600 W. Mt. Royal Ave. |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Do me stic                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 12a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |              |  | 13b. COUNTY<br>Balto.  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1600 Mt. Royal Terr.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>No ah Turner   |              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bu elah Nicholson                 |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>2 20 26 1062  |  | 17. INFORMANT ADDRESS<br>Frances Washington 2461 Shirley Ave.  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____  |              |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |              |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |              |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><u>Margie A. Korell</u>  |              |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                 |  |   |  | DATE SIGNED<br>8-24-82  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |              |  | ADDRESS<br>111 Penn St., Balto., Md. 21201   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |              | 23b. DATE<br>8-28-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Stevensville Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Stevensonville Md. |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Brown/Thompson F.H. 1913 W. Balto. St.   |              |  |  | 25a. DATE REC'D. BY REGISTRAR (25b) REGISTRAR'S SIGNATURE<br>SEP 2 1982 John J. Carver   |   |  |   |  |

MEDICAL CERTIFICATION

(1-1-1)

J

RECEIVED

NOV 19 1964



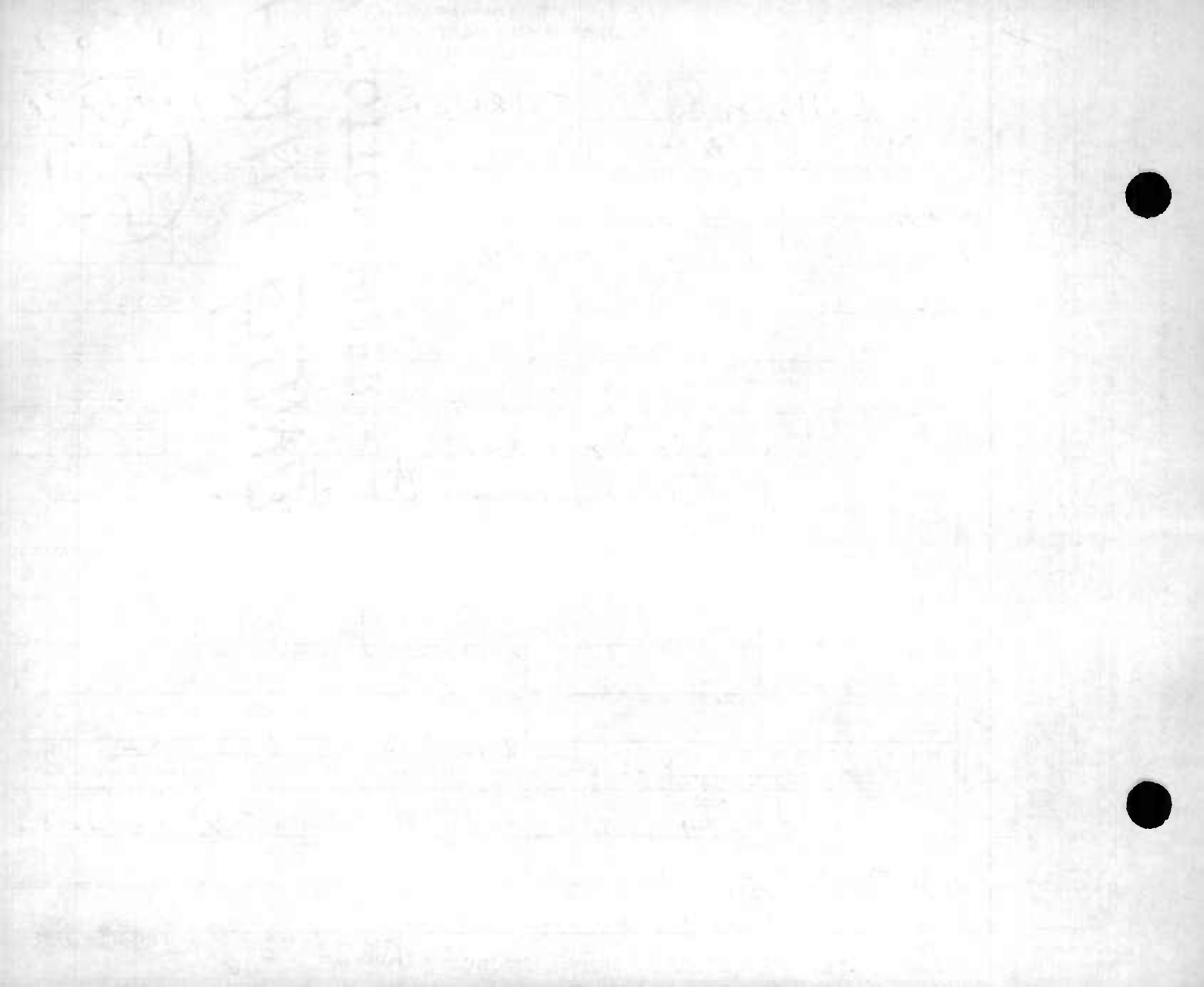
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 2 0 9 6 9

|   |  |  |  |   |  |  |   |  |  |  |
|---|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William R. TURNER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 22 82</b>                  |   |  | 2b. HOUR<br><b>2:15 P.M.</b>   |   |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 24 11</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                 |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Catharine Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>2014 Linden Avenue</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Borkins Turner</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Genebatte Turner</b>  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>224-09-6034</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Hazel Turner 2014 Linden Avenue</b>   |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Pneumonia with Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-12, 19 82</b> , to <b>8-22, 19 82</b> , that (I) (we) last saw the deceased alive on <b>8-22-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>A. Vento, M.D.</b>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8-22-82</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. Vento</b>  |  |  |  |   |  | 22e. ADDRESS   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>8/27/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem</b>      |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 24 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John S. Smith</b>   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 0 9 7 0<br>REG. NO.  |  |  |  |               |  |
|---|--|--|--|---|--|---|--|--|--|--|--|---------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mabel</b>   |  |  |  | FIRST<br><b>Tutt</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 9, 1982</b>   |  |  |  | 2b. HOUR<br>M |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 8 25</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3201 Virginia Avenue</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3201 Virginia Avenue</b>   |  |  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Wheatfall</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rebecca Ward</b>  |  |   |  |  |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-14-7508</b>  |  | 17. INFORMANT ADDRESS<br><b>Bernice Montgomery 2518 Park Heights</b>                            |  |  |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 Sudden death - ASHD 5</b><br>IMMEDIATE CAUSE (a) <b>Sudden death - ASHD 5</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Myocardial infarction</b><br>(c) <b>Arrhythmia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Diabetes mellitus, Peptic Ulcer Disease</b>  |  |  |  |   |  |   |  |  |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>7/4</b> 19 <b>82</b> to <b>8/8</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>7/4</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |               |  |
| 22b. SIGNATURE<br><b>X</b>  |  |  |  | DEGREE<br><b>Elija Saunders, M. D.</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/9/82</b>  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS<br><b>2 Hamill Road Ste 320 Balto., Md. # 10</b>   |  |   |  |  |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>8/14/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden of Eternal Hope</b>                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westminster MD</b>  |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |  |   |  | ADDRESS<br><b>1101 E. North Ave,</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 13 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |               |  |

2001-2002 - 424-424-424  
2001-2002 - 424-424-424  
2001-2002 - 424-424-424

2001-2002 - 424-424-424  
2001-2002 - 424-424-424  
2001-2002 - 424-424-424

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 7 1

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 8 28 82   |  | 8 55 PM   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Female  |  | Black   |  | MONTH DAY YEAR<br>8 28 82   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| MARYLAND  |  | USA   |  |   |  | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore   |  | SINAI HOSPITAL  |  |   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Md.   |  |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS   |  |   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |  | 3211 Spaulding Ave  |  |   |  |
|   |  |   |  | SHONTA TYLER  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |
| NO  |  | N/A   |  | Shirley Tyler   |  | 3211 Spaulding  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>7651 IMMEDIATE CAUSE (a) PRE-VIABLE INFANT<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PREMATURITY<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 8/28, 19 82, to 8/28, 19 82, that (1) (we) last saw the deceased alive on 8/28, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.          |  |   |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |
| V. Narayanan MD   |  |   |  |   |  | 8/28/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |
| V. NARAYANAN  |  | SINAI HOSPITAL, NURSERY   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial  |  | 9/3/82  |  | Eastview Mem Pl Baltimore   |  | Md  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Wm C. March F/H   |  | 1101 E. North Ave   |  | SEP 3 1982  |  | John J. Conish  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 2 0 9 7 2<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST ANNA MIDDLE A. LAST UGIANSKY<br><i>ANNA A. UGIANSKY</i>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 8-28-82 11 <sup>30</sup> P. M.   |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR 09 30 12  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---   |  |
| 13a. STATE<br>MARYLAND   |  |   |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS<br>1925 LETITIA AVENUE, 21230   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MICHAEL --- MAZAN   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>KATHERINE --- KUTZ  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>215-52-1587   |  | 17. INFORMANT ADDRESS<br>JOHN UGIANSKY 1925 LETITIA AVENUE, 21230  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac pump failure</i><br>4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septicemic coronary artery stenosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Sepsis, UTI, Pneumonia</i>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-28-82 to 7-28-82, that (I) (we) lost the deceased on 7-28-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 23a. SIGNATURE<br><i>R. Machado MD</i>   |  |   |  | 23b. DEGREE<br>MD   |  | 23c. DATE SIGNED<br>8/28/82  |  |
| 23d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. MACHADO MD   |  |   |  | 23e. ADDRESS<br>St Agnes Hospital, Baltimore MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>08-31-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GLEN HAVEN MEM. PARK  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GLEN BURNIE A.A. MARYLAND  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |  |   |  | 24b. ADDRESS<br>21229   |  | 25a. DATE REC'D BY REGISTRAR<br>AUG 30 1982  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8 2 2 0 9 7 3   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) IRVING UNTERMAN   |  |   |  | AUGUST 26, 1982  |  |   |  |
| 3. SEX MALE  |  | 4. RACE WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR APR. 6, 1906   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 76  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD  |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6314 GREENSPRING AVE. APT. T-2 |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) MFG.  |  | 12b. KIND OF BUSINESS OR INDUSTRY COSMETICS   |  |
| 13a. STATE MARYLAND  |  |   |  | 13b. CITY OR TOWN BALTIMORE  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL UNTERMAN   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA UNKNOWN  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO. 112-01-8294  |  | 17. INFORMANT ADDRESS MRS. JANICE UNTERMAN 6314 GREENSPRING AVE., APT. T-2 #21209  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto mtr</u>   |  |   |  |  |  |   |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASND</u>  |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>diabetes; Ca prostate</u>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>72</u> to 19 <u>82</u> that (I) (we) last saw the deceased alive on 7 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <u>Stanley Rosen</u> DEGREE   |  |   |  | 22c. DATE SIGNED 8/26/82   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY ROSEN, M.D.   |  |
| 22e. ADDRESS   |  |   |  | 22f. DATE REC'D. BY REGISTRAR  |  | 22g. REGISTRAR'S SIGNATURE <u>John J. Carver</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL REMOVAL/BURIAL   |  | 23b. DATE AUG. 27, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY BETH DAVID  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE ELMONT LONG IS. NY  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  | 25. DATE REC'D. BY REGISTRAR SEP 1 1982  |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |                                 | 8 2 2 0 9 7 4  |  |   |  |
|---|--|---|---------------------------------|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |                                 | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Willie Upton</b>  |  |   |                                 | 2a. DATE OF DEATH MONTH DAY YEAR <b>8-21-82</b>  |  | 2b. HOUR <b>12:30</b> M   |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>Black</b>                       | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 1 28</b>   |                                 | 6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Fla.</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sutherland Hospital</b> |                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD.</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN <b>Balto.</b> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>3313 Poplar St.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Sonny Upton</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie</b>   |                                 | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b> (IF YES, GIVE WAR OR DATES)                                    |  |   |  |
| 16a. SOCIAL SECURITY NO. <b>262-24-9230</b>   |  | 17. INFORMANT ADDRESS <b>Annie Bristol-1107-18th St - West Palm, Beach</b>  |                                 |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>1460</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Squamous Cell Carcinoma of Tonsil</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |                                 |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Aspiration Pneumonia</b>  |  |   |                                 |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                 | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2/19/82</b> P.M. 19   |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                 | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/21/82</b> 19 <b>82</b> , to <b>8/21</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>8/21</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |                                 |  |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b>   |  | DEGREE <b>MD</b>  |                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>8/21/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Moge Gebremariam</b>   |  | 22e. ADDRESS  |                                 |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>8/27/82</b>  |                                 | 23c. NAME OF CEMETERY OR CREMATORY <b>Family lot</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>West Palm Beach, Fla.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Leroy J. Dyett</b>   |  | ADDRESS <b>FURNERAL Home</b>  |                                 | 25a. DATE REC'D. BY REGISTRAR <b>AUG 24 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |

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(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |  |  |  |
|---|--|--|--|---|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |   |   |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>EDNA  |   | MIDDLE<br>VALENTINE                           |   | LAST<br>8-4-82   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR        |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 18 93   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.  |  | 2b. HOUR<br>8:59 AM  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>Md.   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto.                   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2208 N. Calvert St. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unkn.   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-05-4173 |   | 17. INFORMANT ADDRESS                         |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br><u>4300</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>FRONTAL SUBARACHNOID BLEED</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</u><br><u>IMMEDIATE</u><br><u>2 WEEKS</u> |  |  |  |   |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>MALNUTRITION / DEHYDRATION</u>  |  |  |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>NONE</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/26</u> 19 <u>82</u> , to <u>8/4</u> 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>8/4</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) did not view the body after death.                                |  |  |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Ann D. Carter</u>  |  |  |  | DEGREE<br><u>MD</u>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>8-4-82</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ANN D. CARTER</u>   |  |  |  | 22e. ADDRESS<br><u>UNION MEMORIAL HOSP.</u>   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Removal</u>  |  | 23b. DATE<br><u>8/7/82</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Anatomy Board</u>  |  |  |  | ADDRESS<br><u>Balto., Md.</u>   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>AUG 10 1982</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Joan J. Camish</u>  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | 8 2 2 0 9 7 6<br>REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Randolph W. Vaughn</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 10, 1982</b>   |  |  |  | 2b. HOUR<br><b>1:00 A M</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 15 02</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Vaughn</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hattie Carr</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-07-2574</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Leroy Vaughn 2 St. Mary's Lane<br/>Norwalk, Conn.</b> |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Hyperthermia, probable neurogenic cause</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Midbrain stroke</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 19, 1982</b> , to <b>August 10, 1982</b> , that <input checked="" type="checkbox"/> (we) lost <b>view the deceased alive on August 10, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Richard A. Lane</b>   |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard A. Lane, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/12/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 11 1982</b>   |  | REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                       |  |   |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

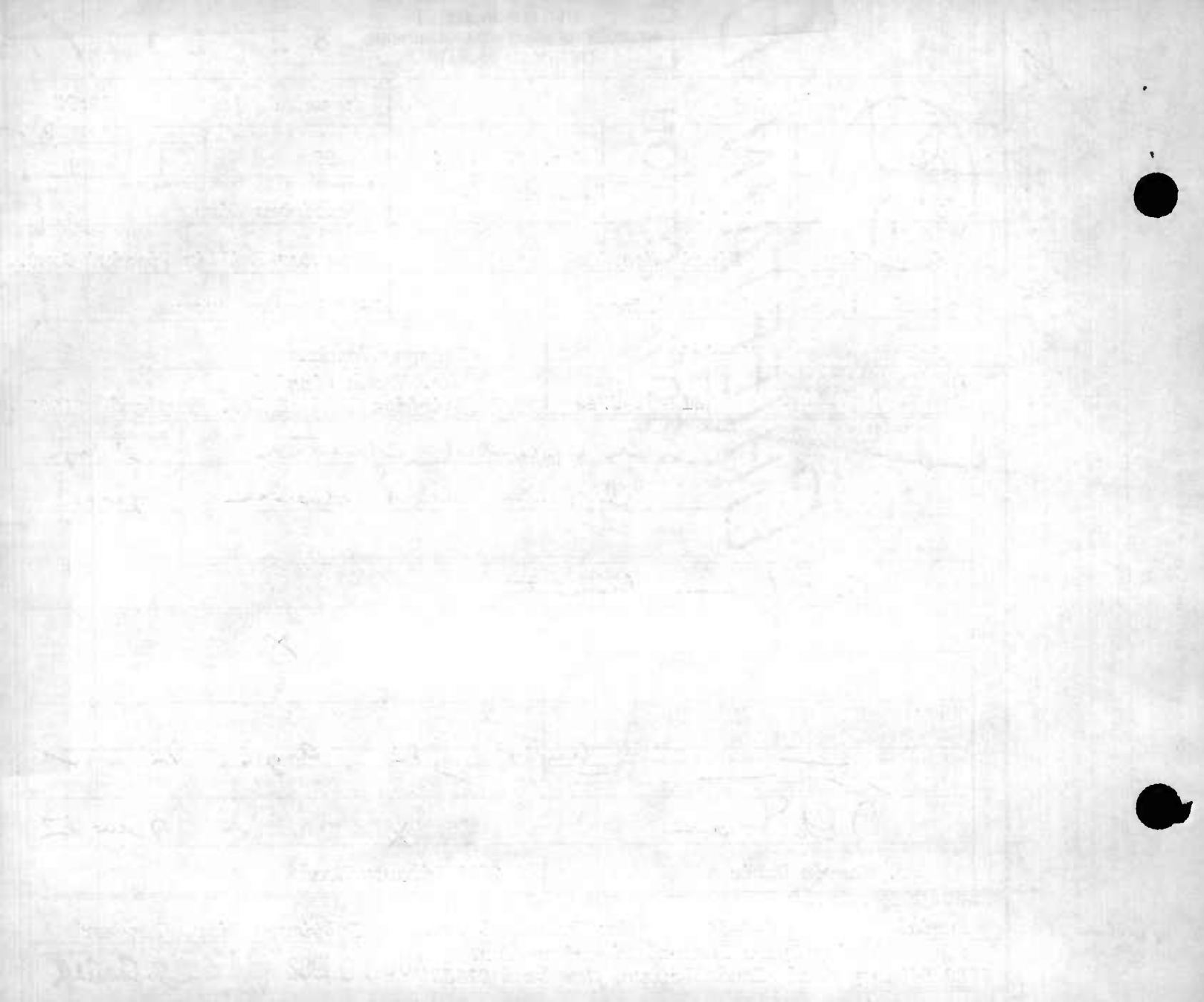
8 2 2 0 9 7 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Salvatore Vizzini</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>August 6, 1982</i> |   |  | 2b. HOUR<br><i>12:07</i> <sup>M</sup>  |  |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Jan. 23, 1894</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>88</i> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Italy</i>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore City</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Sinai Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Carpenter-Phillip Vizzini Cont.</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Balto. City</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 13e. STREET ADDRESS<br><i>3902 Boarman Avenue</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Salvatore Vizzini</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Rozena Vazzana</i>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>-----</i>  |  | 17. INFORMANT<br><i>Mr. Frank Vizzini</i>   |  | ADDRESS<br><i>1455 Clairidge Road Balto. Maryland 21207</i>  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Ischemic heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>years</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Acute &amp; chronic bronchitis</i>  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 5, 1982</i> to <i>Aug 6, 1982</i> , that (I) (we) last saw the deceased alive on <i>Aug 5, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>MD Dr. Marvin Davis</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><i>7 Aug 82</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Marvin Davis</i>  |  |  |  | 22e. ADDRESS<br><i>8507 Liberty Road</i>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>8-9-82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>New Cathedral Cem.</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore City, Maryland</i>                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loring Byers Funeral Directors Inc.</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>AUG 10 1982</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Caswell</i>   |  |  |  |
| 26. ADDRESS<br><i>8728 Liberty Road Randallstown, Maryland 21133</i>  |  |  |  |   |  |  |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

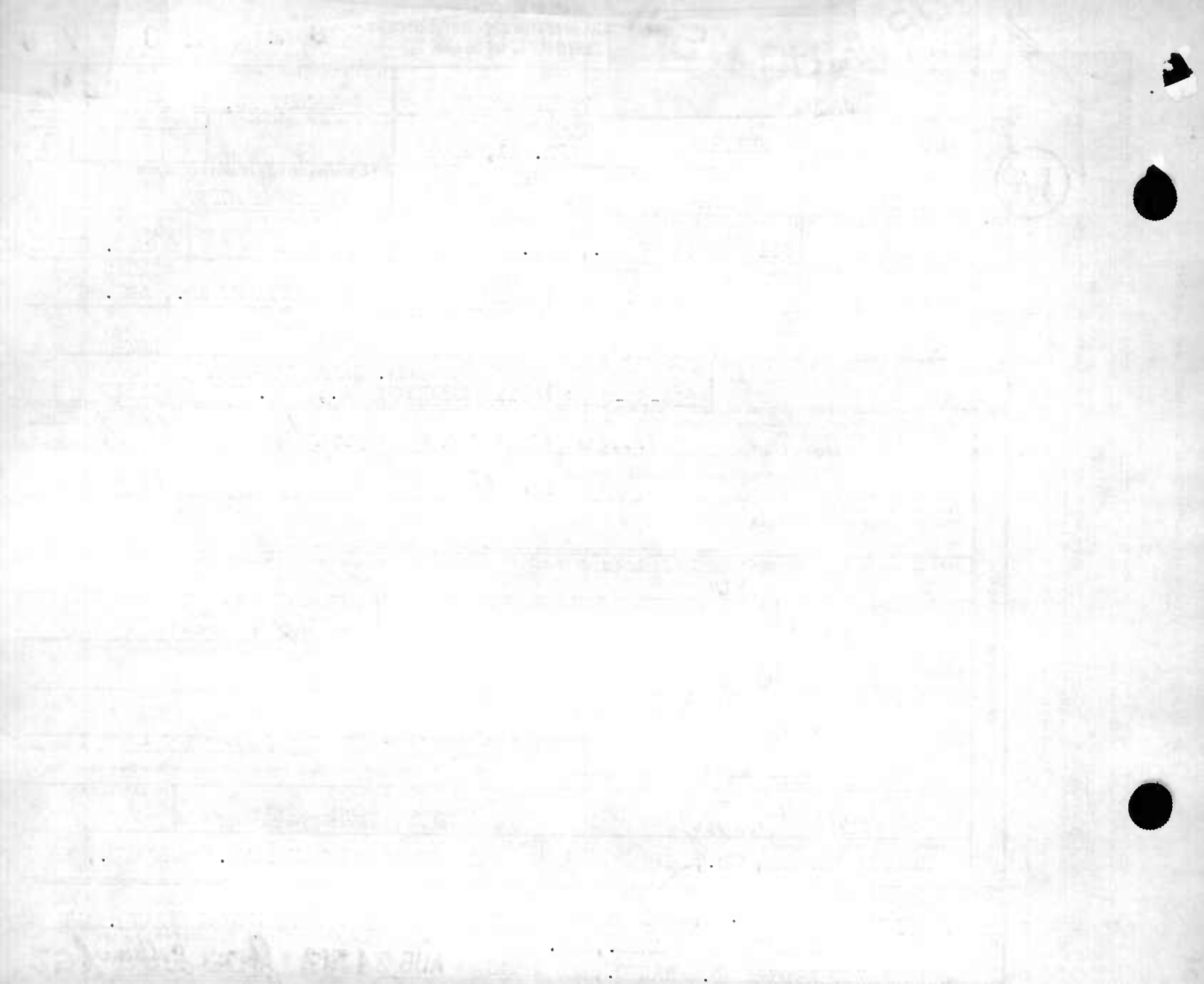
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

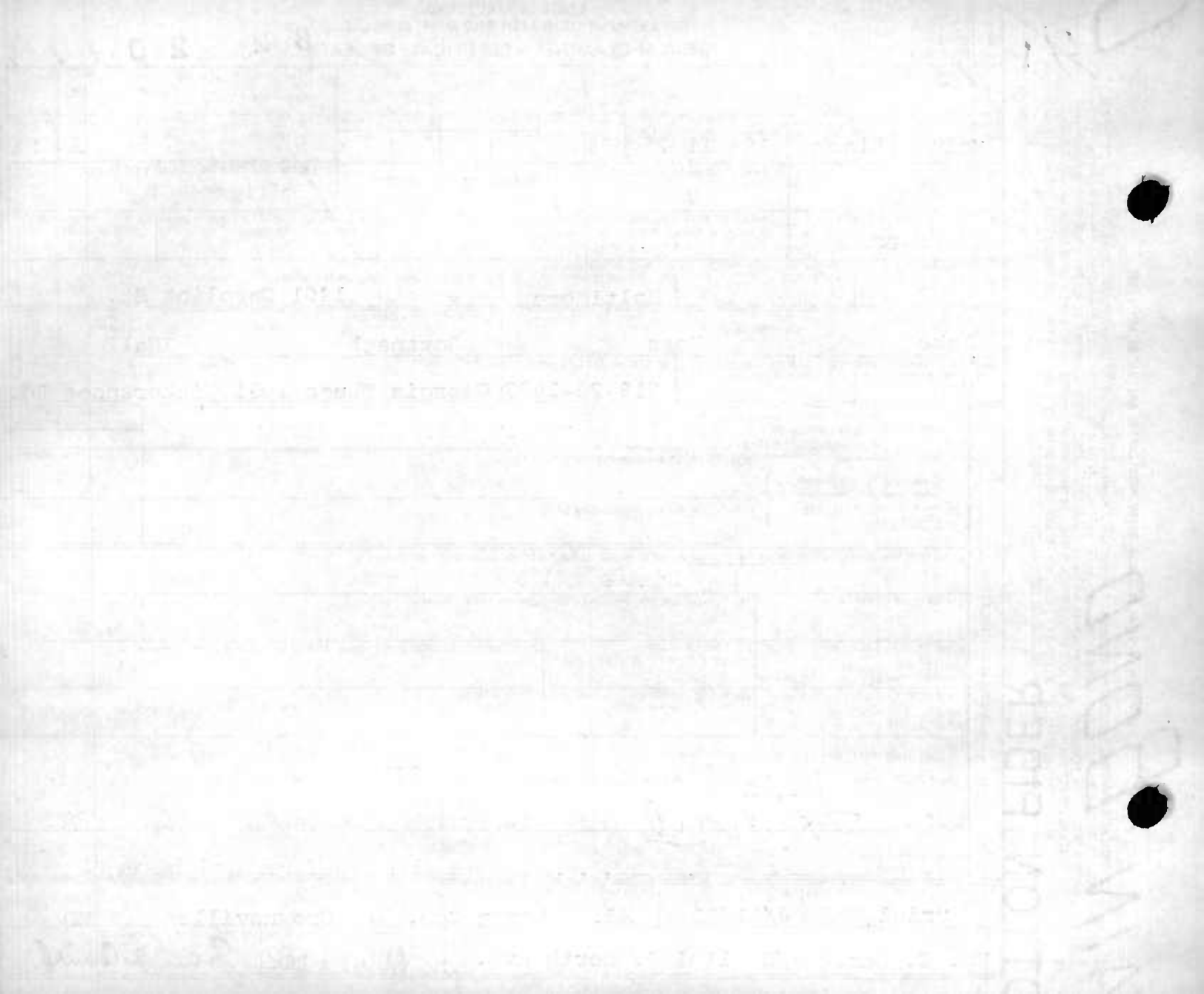
|  |  |  |  |                                      |  |
|--|--|--|--|--------------------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  | 2b. HOUR                             |  |
| JACOB VOGELFANGER  |  | AUGUST 18, 1982  |  | 9 <sup>PM</sup>                      |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                | 7. BALTIMORE CITY OR COUNTY OF DEATH |  |
| MALE   | WHITE  | APR. 11, 1901  | 81 YRS   | BALTIMORE CITY MD                    |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                                      |  |
| ROMANIA  | USA  |  | BALTIMORE CITY MD  |                                      |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                      |  |
| BALTIMORE  | 3116 BANCROFT RD., APT. B  | PACKER   | BALTO. SPICE CO  |                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?   | 13d. STREET ADDRESS  |                                      |  |
| MARYLAND   | BALTIMORE  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 3116 BANCROFT RD., APT. B #21215                               |                                      |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                                      |  |
| ISADORE VOGELFANGER  | ANNA LOW   | NO   |  |                                      |  |
| 16b. SOCIAL SECURITY NO  | 17. INFORMANT  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)                                |  |                                      |  |
| 216-50-0394  | MRS. SARAH VOGELFANGER   | 4100 Acute Myocardial Infarction   |  |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | 12-SCVD  |  |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | 10yr-  |  |                                      |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |  |  |                                      |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                      |  |
| none   | none   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                                      |  |
|  | HOUR A.M. MONTH DAY YEAR   |  |  |                                      |  |
|  | none P.M. 19   |  |  |                                      |  |
| 21d. INJURY OCCURRED   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION  |  |                                      |  |
| WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  | CITY OR TOWN COUNTY STATE  |  |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26 1974 to 8/18 1982, that (I) (we) last saw the deceased alive on 8/18 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |                                      |  |
| 22b. SIGNATURE   | 22c. DATE SIGNED   |  |  |                                      |  |
| Maurice Feldman  |  |  |  |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e. ADDRESS   |  |  |                                      |  |
| MAURICE FELDMAN, JR., MD   | 6610 CROSS COUNTRY BLVD. BALTO., MD  |  |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION  |                                      |  |
| BURIAL   | AUG. 20, 1982  | CHEVRA AHAVAS CHESD  | RANDALLSTOWN BALTO. MD   |                                      |  |
| 24. FUNERAL DIRECTOR NAME  | 25a. DATE REC'D. BY REGISTRAR  |  |  |                                      |  |
| SOL LEVINSON & BROS., INC.   | AUG 24 1982  |  |  |                                      |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  | REGISTRAR'S SIGNATURE                |  |
|  |  |  |  | John J. Gough                        |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |   |  |  |  | REG. NO. 20979   |  |
|--|--|----------------------|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>George Voss</b>  |  |                      |  |   |  | 2a. DATE OF DEATH   |  | 2b. DATE KNOWN OF ESTIMATE   |  | 2c. DATE OF DEATH  |  |
|  |  |                      |  |   |  | MONTH DAY YEAR  |  | MONTH DAY YEAR   |  | MONTH DAY YEAR   |  |
|  |  |                      |  |   |  | 8 5 19 82   |  | 8 5 19 82  |  | 6:04 PM  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 11 25 56</b>          |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) <b>56</b> YRS.                |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GA</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                     |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>   |  |                      |  | 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1401 N. Caroline Street</b>                   |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |   |  |  |  |  |  |
| 13a. STATE <b>MD</b>   |  |                      |  | 13b. COUNTY <b>Baltimore</b>                                |  |   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  |  |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                      |  | 13e. STREET ADDRESS <b>1401 Caroline St.</b>                |  |   |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Jake Voss</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Savanagh Hall</b> |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>218-26-1887</b>                 |  |   |  | 17. INFORMANT ADDRESS <b>Georgia Thugs 1031 Witherspoon Rd.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                      |  |   |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Diabetes Mellitus</b>  |  |                      |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b> |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>[Signature]</b>  |  |                      |  | TITLE (SPECIFY) <b>M.D. Assistant</b>                       |  |   |  | DATE SIGNED <b>8/6/82</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street, Baltimore, MD</b>               |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>8/11/82</b>                                    |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran Cem.</b>      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>  |  |                      |  |   |  | ADDRESS <b>1101 E. North Ave.</b>                               |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                    |  |



## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 8 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |                  |  |  |   |   |
|--|------------------|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Almetta Votta   |                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8/2/82  |  | 2b. HOUR<br>10:25P<br>M   |   |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1/27/10  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72<br>YRS MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |                  | 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Midtown Home                                   |   |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE<br>Maryland   |                  | 12b. COUNTY<br>Baltimore   |  | 12c. CITY OR TOWN<br>Baltimore  |   |
| 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                  | 13b. STREET ADDRESS<br>Midtown Nursing Home  |  | 13c. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mrs. Perle Midtown Nursing Home   |   |
| 14a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |                  | 14b. SOCIAL SECURITY NO.<br>217161759  |  | 14c. INFORMANT<br>Mrs. Perle Midtown Nursing Home   |   |
| 15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>4100 IMMEDIATE CAUSE (a) POSSIBLE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |                  |  |  |   |   |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-1-82 to 8-1-82, that (I) (we) last saw the deceased alive on 8-1-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                  |  |  |   |   |
| 22b. SIGNATURE<br>Ashok K. Chatterjee  |                  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHATTERJEE  |                  | 22e. ADDRESS<br>3927 ANNAPOLIS ROAD 21227  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>8/12/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD   |                  | 23e. DATE REC'D. BY REGISTRAR<br>AUG 11 1982   |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |                  | 24b. REGISTRAR'S SIGNATURE<br>John J. Cahier   |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

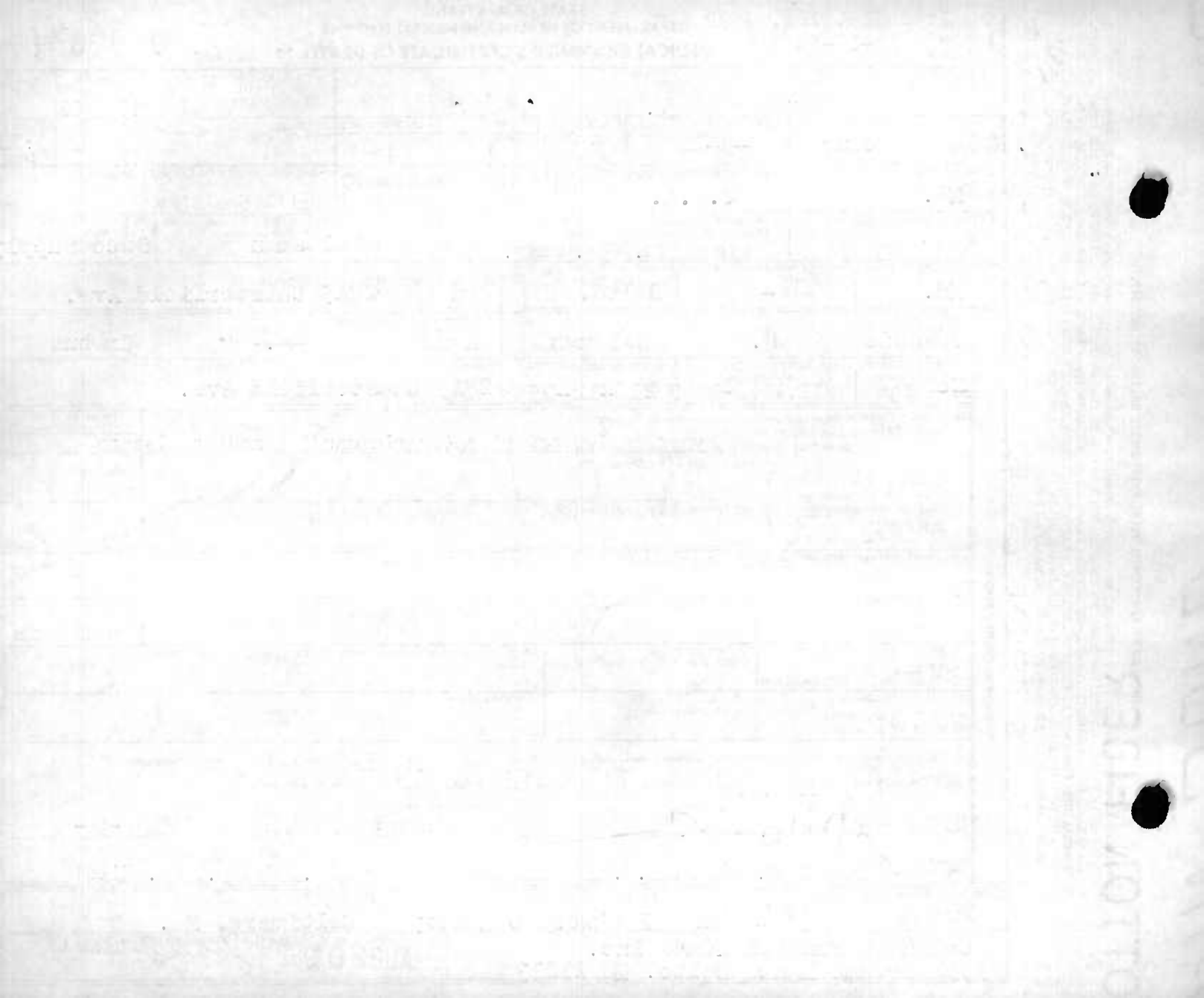
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.)





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |                  |   |                |                  |  |  |  |   | REG. NO. 20981                               |  |
|---|---------|------------------|---|----------------|------------------|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |                  | FIRST MIDDLE LAST   |                |                  | 2a. DATE KNOWN OF DEATH  |  |  | 2b. HOUR  |  |  |
| FRANCIS J. WALDMAN  |         |                  |   |                |                  | 8 17 19 82   |  |  | M   |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)   | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD   |  |  | 2d. HOUR  |  |  |
| Male  | cauc    | 5-3-22           | 60 YRS.   | MONTHS         | DAYS             | 8 17 1982  |  |  | 1:32 P M  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| Md.   |         |                  | U.S.A.  |                |                  |  |  |  | Baltimore City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Baltimore   |         |                  | South Balto. Gen. Hosp. (DOA)   |                |                  | Salesman   |  |  | Saco Supply   |  |  |
| 13a. STATE  |         |                  | 13b. COUNTY   |                |                  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |  |
| Md.   |         |                  | -   |                |                  | Balto.   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME  |                |                  | 13e. STREET ADDRESS  |  |  |   |  |  |
| Francis H. Waldman  |         |                  | Agnes S. D. Grabus  |                |                  | 2845 Chesterfield Ave.   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         |                  | 16b. SOCIAL SECURITY NO.  |                |                  | 17. INFORMANT ADDRESS  |  |  |   |  |  |
| No Yes  |         |                  | WWII, 1942-1945   |                |                  | 2845 Chesterfield Ave.   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                  |   |                |                  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:   |         |                  |   |                |                  |  |  |  |   |  |  |
| IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease  |         |                  |   |                |                  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |   |                |                  |  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |         |                  |   |                |                  |  |  |  |   |  |  |
| (b)   |         |                  |   |                |                  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |   |                |                  |  |  |  |   |  |  |
| (c)   |         |                  |   |                |                  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |         |                  |   |                |                  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                |                  |  |  |  | 20. AUTOPSY?  |  |  |
|   |         |                  |   |                |                  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |
|   |         |                  | P.M. 19   |                |                  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                |                  | 21f. LOCATION  |  |  |   |  |  |
|   |         |                  |   |                |                  | CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                  |   |                |                  |  |  |  |   |  |  |
| ACTUAL SIGNATURE  |         |                  | TITLE (SPECIFY)   |                |                  |  |  |  | DATE SIGNED   |  |  |
| Ann M. Dixon, M.D.  |         |                  | M.D. Assistant MEDICAL EXAMINER   |                |                  |  |  |  | 8-18-82   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         |                  | ADDRESS   |                |                  |  |  |  |   |  |  |
| Ann M. Dixon, M.D.  |         |                  | 111 Penn St., Balto., Md. 21201   |                |                  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |                  | 23b. DATE   |                |                  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION   |  |  |
| Burial  |         |                  | 8/21/82   |                |                  | Parkwood Cemetery  |  |  | Baltimore, Md.  |  |  |
| 24. FUNERAL DIRECTOR  |         |                  | 25a. DATE REC'D. BY REGISTRAR   |                |                  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| Schimunek Funeral Homes Inc.  |         |                  | AUG 20 1982   |                |                  |  |  |  | John J. Smith   |  |  |
| 3331 Brehms Lane Balto. Md 21213  |         |                  |   |                |                  |  |  |  |   |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |               |   |  |   |  |   |                      |  |  |   |  |   |                       |   |  |  |  |
|--|--|------------------|---------------|---|--|---|--|---|----------------------|--|--|---|--|---|-----------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>PAUL |   |  | MIDDLE<br>EDWARD  |  |   | LAST<br>WALDMANN JR. |  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>8-17-82  |  |   | 2b. HOUR<br>M<br>2:21 |   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE |               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12.28.1910  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>71 YRS.               |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |                      | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>8-17-82            |  | 2d. HOUR<br>M<br>2:21   |  |   |                       |   |  |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |                  |               | 7c. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                      |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |                       |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |                  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITAL |  |   |  |   |                      |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OPERATING ENGINEER             |  |   |                       | 12b. KIND OF BUSINESS OR INDUSTRY<br>UNION      |  |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13. STATE<br>MARYLAND   |  |                  |               | 13b. CITY OR TOWN<br>BALTO.   |  |   |  | 13c. CITY OR TOWN<br>MILLERS ISLAND   |                      |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |                       | 13e. STREET ADDRESS<br>9014 CUCKOLD POINT 21219 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>PAUL WALDMANN  |  |                  |               |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MAMIE LAUGHLIN   |                      |  |  |   |  |   |                       |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, IF UNKNOWN) NO   |  |                  |               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213.07.0725  |  |   |  | 17. INFORMANT<br>ADDRESS<br>ELIZABETH M. WALDMANN (SAME AS 13e)   |                      |  |  |   |  |   |                       |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |               |   |  |   |  |   |                      |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                       |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |               |   |  |   |  |   |                      |  |  |   |  |   |                       |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |                      |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                      |  |  |   |  |   |                       |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      |  |  |   |  |   |                       |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |                  |               |   |  |   |  |   |                      |  |  |   |  |   |                       |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |  |                  |               | TITLE (SPECIFY)<br>Assistant  |  |   |  | MEDICAL EXAMINER  |                      |  |  | DATE SIGNED<br>8-17-82  |  |   |                       |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |  |                  |               | ADDRESS<br>111 Penn Street  |  |   |  |   |                      |  |  |   |  |   |                       |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  |                  |               | 23b. DATE<br>8/21/1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT CREMATORY |  |   |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |  |   |  |   |                       |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222   |  |                  |               |   |  |   |  |   |                      | 25a. DATE REC'D. BY REGISTRAR<br>AUG 18 1982                     |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>   |  |   |                       |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | 7 2 2 0 9 8 3    |     |  |          |                            |  |
|---|--|--|--|--|--|--|--|--|--|------------------|-----|--|----------|----------------------------|--|
| 1- FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH  |  | MONTH            | DAY | YEAR   | 2b. HOUR |                            |  |
| Charles E. Walker   |  |  |  |  |  |  |  | 8  |  | 14               | 82  | 8:20 P.M.                                    |          |                            |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |     |  |          |                            |  |
| male  |  | Black  |  | 12 MONTH 19 DAY 09   |  | 72 YRS.  |  | MONTHS   |  | DAYS             |     | HOURS MIN.                                   |          |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |                  |     | MD.  |          |                            |  |
| Virginia  |  | USA  |  |  |  | Baltimore  |  |  |  |                  |     |  |          |                            |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                  |     |  |          |                            |  |
| Balto   |  | North Charles Gen.   |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |                  |     |  |          |                            |  |
| Md.   |  |  |  | Balto  |  |  |  | 5009 Palmer Ave.   |  |                  |     |  |          |                            |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| Edward  |  | Annie  |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |  |  |                  |     |  |          |                            |  |
| NO  |  | 213-10-8278A   |  | Loriane Walker   |  | 5009 Palmer Ave.   |  |  |  |                  |     |  |          |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CA OF THE STOMACH  |  |  |  |  |  |  |  |  |  |                  |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |                            |  |
| 1519  |  |  |  |  |  |  |  |  |  |                  |     | YEAR   |          |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| MEDICAL CERTIFICATION   |  |  |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                  |     |  |          |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |                  |     |  |          |                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                  |     |  |          |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 22, 19 82, to August 14, 19 82, that (I) (we) last saw the deceased alive on August 14, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| 22b. SIGNATURE DEGREE   |  |  |  |  |  |  |  |  |  |                  |     | 22c. DATE SIGNED                             |          |                            |  |
| R G A BOLAND  |  |  |  |  |  |  |  |  |  |                  |     | 8 14 82                                      |          |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  |                  |     | 22e. ADDRESS                                 |          |                            |  |
| 2724 N. CHARLES ST  |  |  |  |  |  |  |  |  |  |                  |     |  |          |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |                  |     |  |          |                            |  |
| Burial  |  | 8/19/82  |  | Arbutus Mem. PK  |  | Balto. Md.   |  |  |  |                  |     |  |          |                            |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  |  |  |  |  |  |                  |     | 25a. DATE REC'D. BY REGISTRAR                |          | 25b. REGISTRAR'S SIGNATURE |  |
| Leroy O. Sytt 4600 Liberty Sq. Dr.  |  |  |  |  |  |  |  |  |  |                  |     | AUG 15 1982                                  |          | John J. Carver             |  |

1. The first part of the document is a letter from the President of the United States to the Congress, dated March 1, 1801. It is a very important document, as it is the first time that the President has addressed the Congress in a formal letter. The letter is written in a very formal and dignified style, and it is a very good example of the style of the time.

2. The second part of the document is a letter from the President to the Congress, dated March 1, 1801. It is a very important document, as it is the first time that the President has addressed the Congress in a formal letter. The letter is written in a very formal and dignified style, and it is a very good example of the style of the time.

3. The third part of the document is a letter from the President to the Congress, dated March 1, 1801. It is a very important document, as it is the first time that the President has addressed the Congress in a formal letter. The letter is written in a very formal and dignified style, and it is a very good example of the style of the time.

4. The fourth part of the document is a letter from the President to the Congress, dated March 1, 1801. It is a very important document, as it is the first time that the President has addressed the Congress in a formal letter. The letter is written in a very formal and dignified style, and it is a very good example of the style of the time.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director and should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 8 4

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |   |  |   |                  |  |                                  |   |          |  |          |                               |        |  |
|---|--|---|--|---|------------------|--|----------------------------------|---|----------|--|----------|-------------------------------|--------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Clara  |  | MIDDLE<br>E.  | LAST<br>Walkling |  | 2a. DATE OF DEATH MONTH DAY YEAR |   | 08/09/82 |  | 2b. HOUR |                               | 06:10P |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec 31, 1911  |                  | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                  | 70  |          | IF UNDER 1 YEAR<br>MONTHS DAYS   |          | IF UNDER 24 HRS<br>HOURS MIN. |        |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |                                  |   |          |  |          |                               |        |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN STATE HOSPITAL, GIVE STREET AND ADDRESS)<br>John Hopkins Hospital |  |   |                  |  |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |          | 12b. KIND OF BUSINESS OR INDUSTRY  |          |                               |        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MD  |  |   |  | 13b. COUNTY   |                  | 13c. CITY OR TOWN<br>Balto.  |                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          | 13e. STREET ADDRESS<br>East<br>5002 Biddle St  |          |                               |        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ewald Brauer  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Weinreich   |                  |  |                                  |   |          |  |          |                               |        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-05-9440  |                  | 17. INFORMANT<br>ADDRESS<br>Freda Nortrup 2202 Westridge Rd  |                                  |   |          |  |          |                               |        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer (transitional cell, metastatic)</u><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |                  |  |                                  |   |          |  |          |                               |        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |                  |  |                                  |   |          |  |          |                               |        |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                  |  |                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |          |                               |        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                  |   |          |  |          |                               |        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                  |   |          |  |          |                               |        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>82</u> , to <u>8/9</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |                  |  |                                  |   |          |  |          |                               |        |  |
| 22b. SIGNATURE<br><u>Drew Pardoll MD</u>  |  |   |  |   |                  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                  |   |          | 22c. DATE SIGNED<br>8/9/82   |          |                               |        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Drew Pardoll   |  |   |  |   |                  | 22e. ADDRESS<br>Johns Hopkins Hospital   |                                  |   |          |  |          |                               |        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>8/13/82  |                  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park  |                                  |   |          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD  |          |                               |        |  |
| 24. FUNERAL DIRECTOR<br>NAME SCHIMUNEK FUNERAL HOME, INC<br>ADDRESS 3331 Brehms Lane Balto, MD 21213  |  |   |  |   |                  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 13 1982   |                                  |   |          | 25b. REGISTRAR'S SIGNATURE<br>John J. Smith  |          |                               |        |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be marked on page 1.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 8 5

REG. NO.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM Henry WALLACE</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 4 1982</b>      |   | 2b. HOUR<br><b>7:07 PM</b>                   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 6 18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Wallace</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Delzina Lee</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>218/03/3329</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Margaret Forks 2733 Gatehouse Drive</b>                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral pneumonia with abscess</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Anemia</b>  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 10</b> 19 <b>82</b> , to <b>August 4</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>August 4</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Guillermo Sora</b>   |   | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8-4-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. VERGARA-SORRE</b>  |   | 22e. ADDRESS<br><b>N. CHARLES GEN. HOSP. BALT. MD. 21218</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>8/9/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem</b>                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |   |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 10 1982</b>  |  |   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |   |  |

11/10

Received from the bank

Jan 10 1910

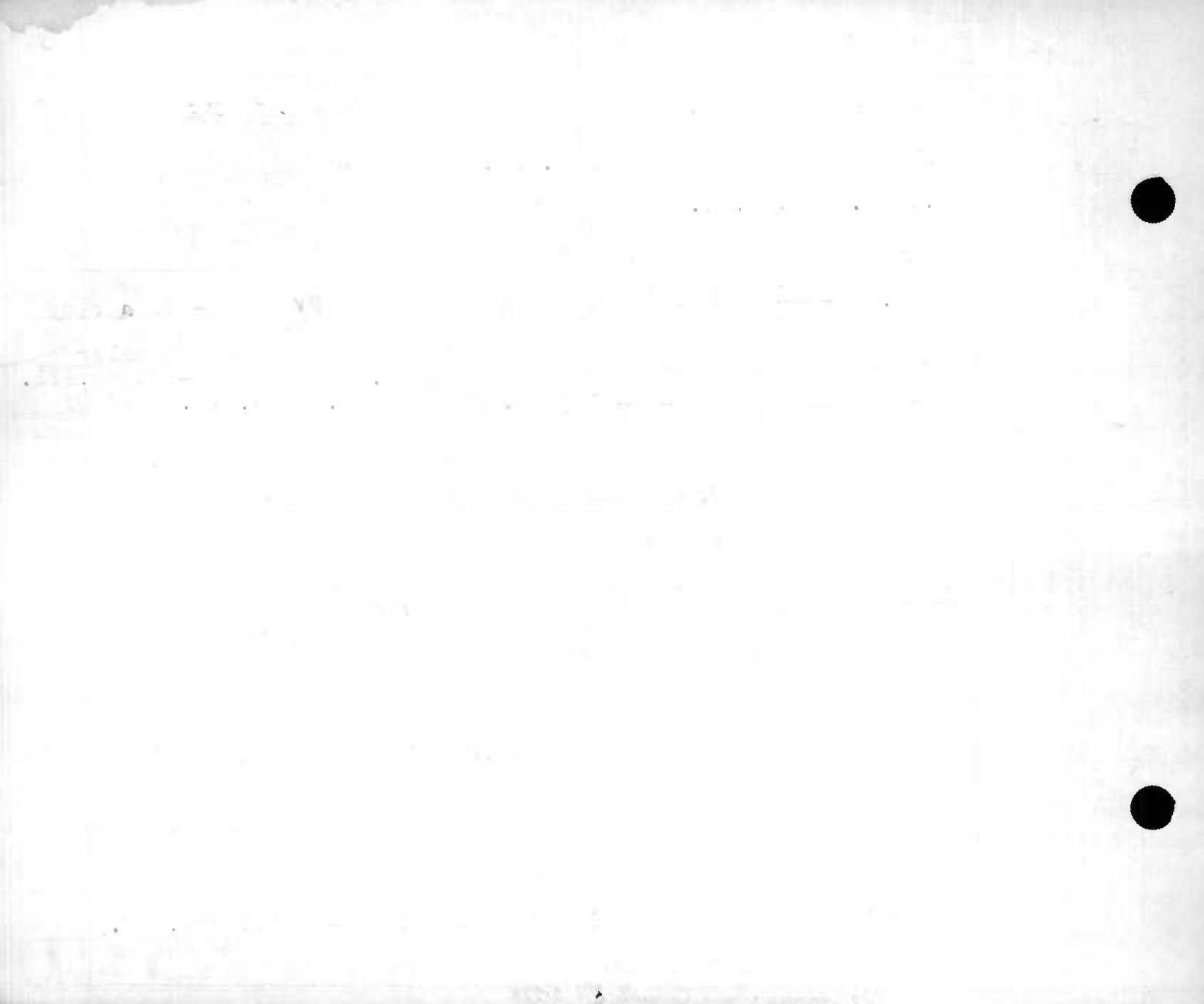
RECEIVED FROM THE BANK  
11 10 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                    | 8 2 2 0 9 8 6  |  |   |   |
|--|--|---|--------------------|--|--|---|---|
| FOR<br>STATE<br>REGISTRAR  |  |   |                    | REG. NO.   |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BESSIE</b>   |  |   | FIRST<br><b>W.</b> | MIDDLE<br><b>WARD</b>  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 22 1982</b> |   | 2b. HOUR<br><b>9:15 A</b>                       |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 26, 1898</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balt., Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                    | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bank</b>  |   |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |                    | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Severn Wells</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Elizabeth Henzler</b>  |                    | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-74-8217</b>  |   |
| 17. INFORMANT<br><b>Mr. Dederick W. Ward, III.</b>   |  | 18. ADDRESS<br><b>411 W. High Street-Urbana, Ill.</b>   |                    | 19. PHONE NO.<br><b>61801</b>  |  | 20. DATE OF DEATH<br><b>August 22 1982</b>  |   |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>4329</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PROBABLE INTRACRANIAL BLEED</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PULMONARY EMBOLISM</b>                                 |  |   |                    |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>DEEP VENOUS THROMBOSIS OF LEG</b>   |  |   |                    |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 21, 1982</b> , to <b>August 22, 1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>August 22, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |                    |  |  |   |   |
| 22b. SIGNATURE<br><b>Ann D. Carter, MD</b>   |  | DEGREE  |                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>8/22/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANN D. CARTER</b>  |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |                    |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/24/82</b>   |                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Starling Funeral Estate</b>   |  | ADDRESS<br><b>136 Edmondson Ave. - Catonsville, Md. 21228</b>   |                    | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 25 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |   |

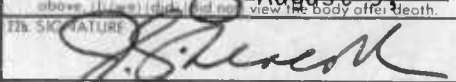
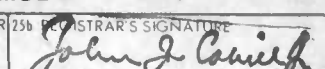


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 2 0 9 8 7  |  |  |  |
|---|--|--|--|--|--|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Daisy E. Ward</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 10, 1982</b>  |  | 2b. HOUR<br>M<br><b></b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 2 23</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>59</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2111 Callow Avenue</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b></b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>  |  | 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b></b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence Bishop</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Verdella Brown</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2111 Callow Avenue</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-18-3576</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Ernest B. Ward 2111 Callow Avenue</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Carcinoma of lung with metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>July, 1979</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1979</b> , to <b>present</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>August 9, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>   |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8/10/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>F.S. Leacock, M.D., P.A.</b>  |  |  |  | 22e. ADDRESS<br><b>3502 W. Rogers Avenue, Balto. Md. 21215</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/14/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>AUG 11 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br>        |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 8 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |                                   |
|--|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>RUTH Virginia WARD</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>08-20-82</b>   |   | 2b. HOUR<br><b>5<sup>20</sup> P.M.</b>  |                                   |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>C I</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>06-05-25</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>57</b>                     |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City MD.</b>                 |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LPN in STATE HOSP.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE COUNTY CITY OR TOWN<br><b>35 BALTO RELISTARTOWN MD</b>  |  | 14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13. STREET ADDRESS<br><b>316 CHERRY HILL RD.</b>                                  |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JAMES KUYKENDALL</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>DELLA GRAPES</b>   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)<br><b>NO</b> |                                   |
| 16a. SOCIAL SECURITY NO.<br><b>212-240932</b>  |  | 17. INFORMANT<br><b>ROY WARD</b>  |   | ADDRESS<br><b>316 CHERRY HILL RD. RELISTARTOWN, MD</b>                            |                                   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4590</b> IMMEDIATE CAUSE (a) <b>Massive hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Probable Fistula between airway and major vessel</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |                                   |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>Pulmonary edema - 4 Myocardial Infarctions</b>  |  |   |   |   |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)          |   |   |                                   |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |   |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>07-18-82</b> to <b>08-20-82</b> , that (I) (we) last saw the deceased alive on <b>08-20-82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |   |   |   |                                   |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>  |   | 22c. DATE SIGNED<br><b>08-20-82</b>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TERESA TIFFERT</b>   |  | 22e. ADDRESS<br><b>Sinai Hospital of Baltimore</b>  |   |   |                                   |
| 22f. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Aug. 23, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>                     |                                   |
| 23d. LOCATION<br><b>Pikesville, Balto., Md.</b>  |  | 24. FUNERAL DIRECTOR<br><b>Edmund</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 24 1982</b>                               |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  | 25c. ADDRESS<br><b>Owings Mills, Md.</b>  |   |   |                                   |

• 1948, 1949, 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



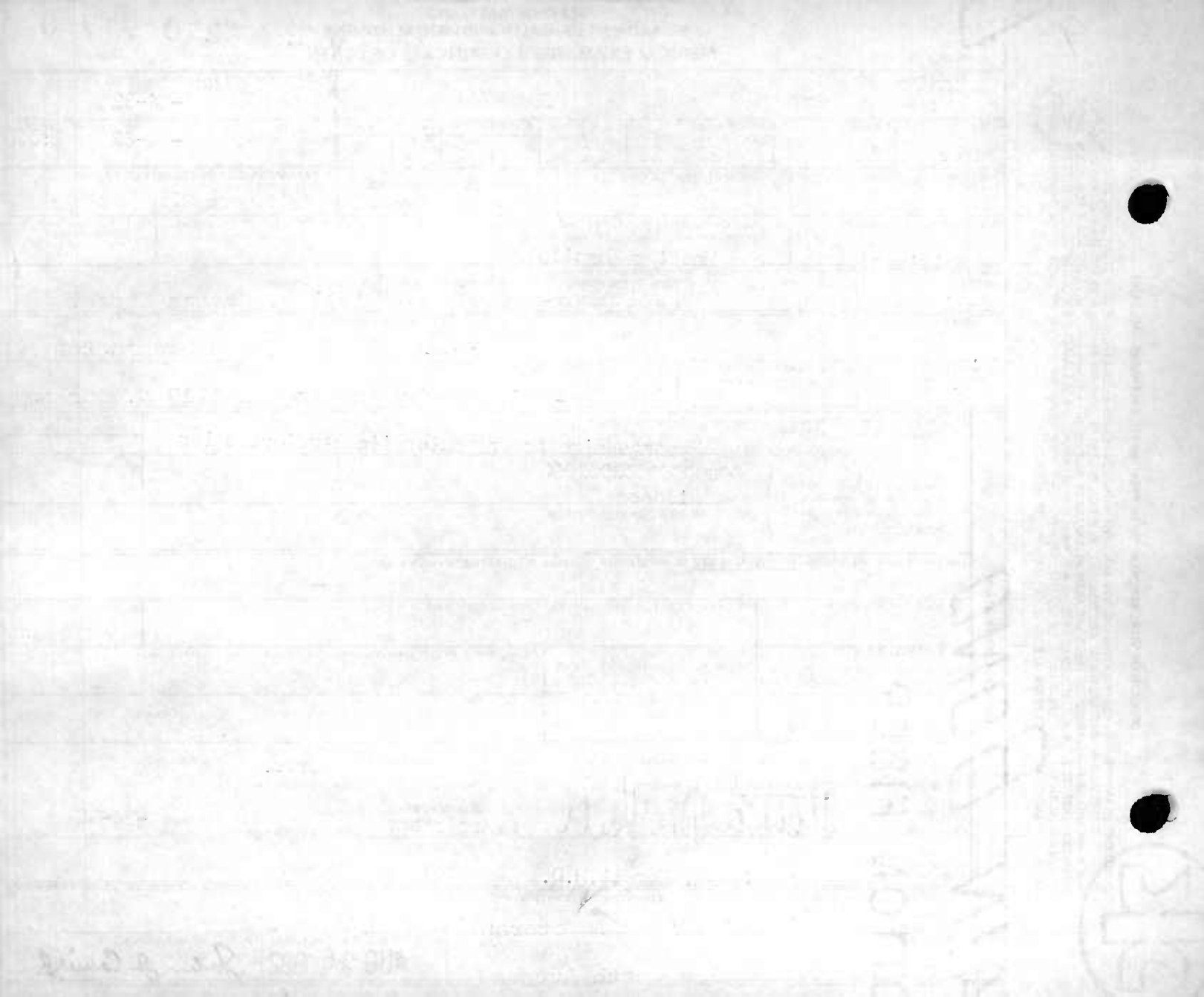
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR <b>Clifton O. Washburn</b>  |  |  |  |  | 8 2E0 53 35 25 8 9<br>CERTIFICATE OF DEATH                             |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>CLIFTON O. WASHBURN</b>  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 8 17 82 2b. HOUR 8 <sup>22</sup> A.M. |   |  |   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 19 14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.                                    |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                    |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Conductor</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Baltimore</b>  |  |  |  |  | 13c. CITY OR TOWN <b>Catonsville</b>                                   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Levin Washburn</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Martin</b>          |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>214-10-8568</b>                            |   | 17. INFORMANT <b>500 Bathurst Rd. Emma E. Washburn - Catonsville, Maryland 21222</b>         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>45 min - 1 hr</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION _____   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR _____ P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____   |  |   |  |   |  |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____  |  | 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>17 August</b> 19 <b>82</b> to <b>17 August</b> 19 <b>82</b> that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>17 August</b> 19 <b>82</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Andrew Trofa</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |  |  | 22c. DATE SIGNED <b>17 Aug 1982</b>                                    |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREW TROFA</b>  |  |  |  |  | 22e. ADDRESS <b>900 CATON AVE BALTIMORE MD 21221</b>                   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>August 20, 82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Fk.</b>   |  | 23d. LOCATION CITY OR TOWN <b>Dorsey</b> COUNTY <b>Howard</b> STATE <b>MD.</b>    |  |   |  |
| 24. FUNERAL RECORD OR NAME <b>Leroy M. &amp; Russell C. Witzke Funeral Home P.A.</b>   |  |  |  |  |  | 25a. DATE RECD. BY REG. CLERK <b>AUG 19 1982</b>                                  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>  |  |
| 26. ADDRESS <b>1630 Edmondson Ave., Catonsville, MD. 21228</b>   |  |  |  |  |  |   |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

0806 BP  
DHMH - 17  
(VR A15 ME (5))  
20MA 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |   |  |   |  | REG. NO. 20990   |  |
|--|--|------------------|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                  |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ARTHUR WASHINGTON  |  |                  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>8-24-82 |  |
| 3 SEX<br>Male  |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 27 20   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>62                                    |  | IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>8-24-82   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John Hopkins Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1717 N. Durham Street   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Katie Green-Washington          |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes  |  |                  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>218-10-5961  |  | 17. INFORMANT ADDRESS<br>Dorothy Washington 1717 N. Durham                    |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular</u><br>XXXXXXXXXXXXXXXXXXXX<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <u>disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |                  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                  |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |   |  | DATE 8-24-82<br>SIGNED  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |  |                  |  | ADDRESS 111 Penn Street  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |                  |  | 23b. DATE<br>8/27/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Crownville Md.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 E. North Avenue   |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 26 1982                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>   |  |  |  |





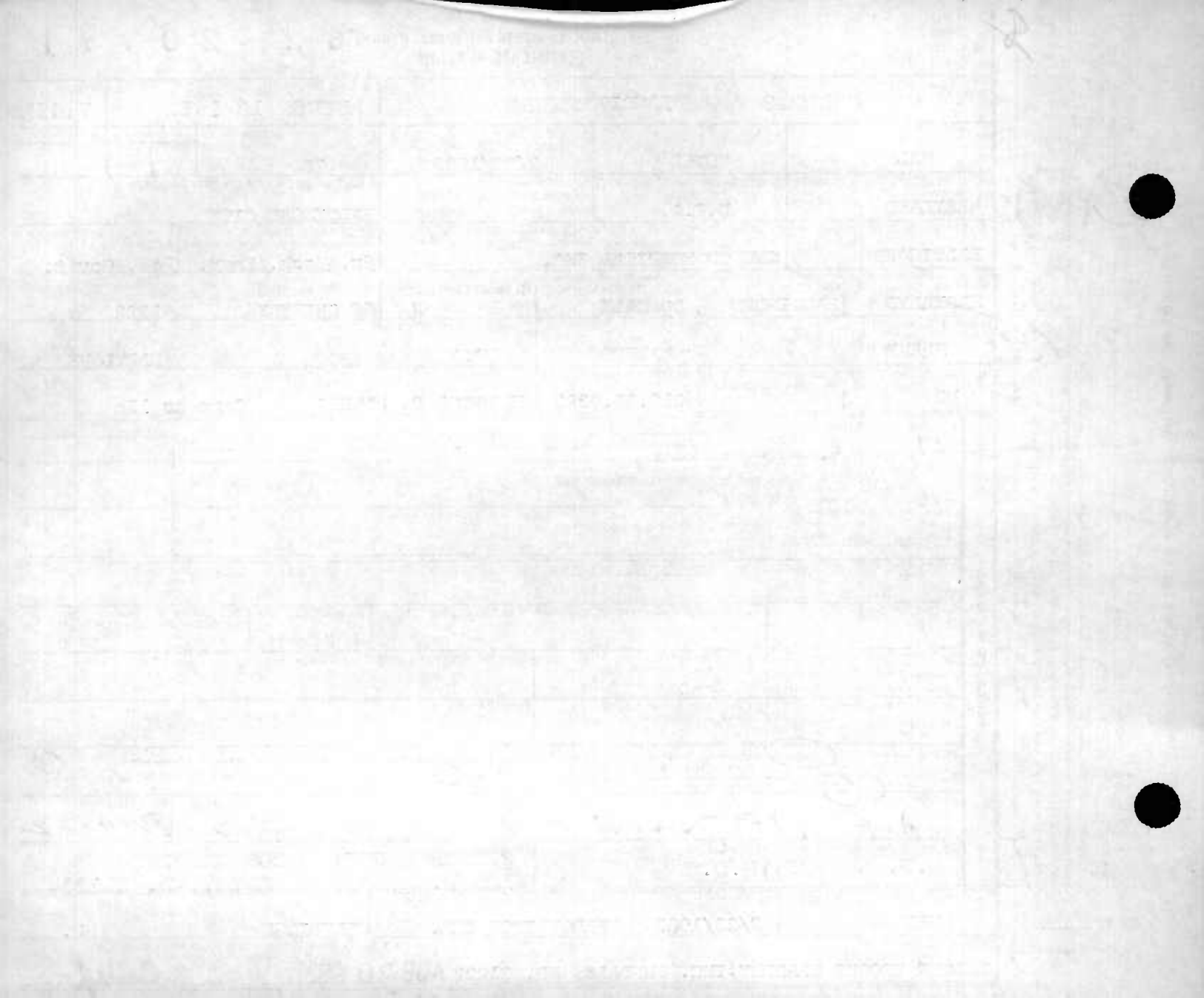
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the medical director. Page 4 should be filed in the office of the registrar. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical director must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES F RANCIS WATERS</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 19 1982</b>          |  |  | 2b. HOUR<br><b>7:45 AM</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2/22/1906</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL INC.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sr. Mech. Engr.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fed. Gov't.</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>66 SHIPWAY</b>   |  | 21222  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK WATERS</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY HARTLOVE</b> |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218.22.0292</b>   |  | 17. INFORMANT<br><b>MINNETTA C. WATERS</b>  |   | ADDRESS<br><b>Same as 13e</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: <b>CARCINOMA OF THE LUNG WITH METASTASES</b><br><b>1629</b> IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 17 1982</b> , to <b>AUGUST 19 1982</b> , that (I) (we) (we) saw the deceased alive on <b>AUGUST 19 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.  |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>A.F. Nazemi</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   | 22c. DATE SIGNED<br><b>8/19/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.F. NAZEMI, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTO. MD. 21231</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8/23/1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE CEM.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE MD.</b>                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 20 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James A. Smith</b>  |  |  |  |

BP \_\_\_\_\_



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 9 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROY</b>   |  |  | FIRST MIDDLE LAST<br><b>WATERS</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 1 82</b>  |  |  | 2b. HOUR<br><b>2:31 PM</b>  |  |  |
| 3. SEX<br><b>M</b>  |  |  | 4. RACE<br><b>B</b>   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 14 24</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MO</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hosp.</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>MO</b>   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 13e. STREET ADDRESS<br><b>776 Hamburg St.</b>   |  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Tom Green</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Dora McClain</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-18-5152</b>  |  |  | 17. INFORMANT ADDRESS<br><b>Angela Thompson 425 N. Patterson Ave.</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>(IMMEDIATE CAUSE (a)) <b>Cardiopulmonary arrest</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CIT COPD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>pneumonia</b> |  |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>776 82 St Baltimore MO</b>  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/31</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Kuang-Yen Huang</b>  |  |  | DEGREE<br><b>M.D.</b>   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  | 22c. DATE SIGNED<br><b>8/1/82</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>   |  |  | 22e. ADDRESS<br><b>Lutheran Hospital</b>  |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>8/6/82</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemo</b>   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore MO</b>  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 06 1982</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, Pages 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8 2 2 0 9 9 3  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOSEPH A WATKINS</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 8 82</b>   |  | 2b. HOUR<br><b>2:05pm</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 23 17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>65</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b></b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b></b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Moses Watkins</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lucy Taylor</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>226-18-7574</b>  |  | 17. INFORMANT ADDRESS<br><b>Eloise Watkins 1619 Division St.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LARGE CELL ADENOCARCINOMA OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br><b>1 year</b> |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 mins</b>  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>BRAIN METASTASIS, SPINAL CORD METASTASIS</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 1</b> , 19 <b>82</b> , to <b>Aug 8</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Aug 8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Daniel E. Ford, M.D.</b>  |  |   |  | DEGREE<br><b></b>   |  | 22c. DATE SIGNED<br><b>8/8/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL E. FORD, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL, BALT. MD. 21205</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8/12/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Meherrian VA</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE<br><b>AUG 11 1982 John J. Canfield</b>   |  |   |  |

WASHINGTON STATE

JOHN H. HARRIS

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THE STATE OF WASHINGTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. These pages require separate signatures. Page 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at 1-800-338-2673.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |   |  |  |  |  |  |  |  |
|--|--|---|--|---|--|---|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   | 7 2 2 0 9 9 4  |   |   |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.   |   |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE V. WATSON, III</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>AUGUST 16, 1982</b>             |   |   |  |  | 2b. HOUR<br><b>09:16AM</b>   |  |  |  |  |
| 1. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 18 19</b>   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                                 |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Draftsman</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>  |  |  |  |  |
| 13a. STATE<br><b>PA</b>  |  | 13b. COUNTY<br><b>York</b>  |  | 13c. CITY OR TOWN<br><b>York</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1795 Sagamore Drive</b>  |  |  |  |  |  |  |
| FATHER'S NAME FIRST MIDDLE LAST<br><b>George V. Watson, Jr.</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Marguerite Doring</b> |   |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 187-10-8213</b>  |  | 17. INFORMANT ADDRESS<br><b>Mary Watson, 1795 Sagamore Dr., York, PA</b>                        |   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1509 IMMEDIATE CAUSE (a) Pulmonary Embolism (Probable cause)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>post-operative condition</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>post esophageal cancer resection</b>                                  |  |   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one hour</b>  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><b>post esophageal cancer resection</b>   |  |   |  |   |  |   |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>August 10, 1982</b>   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>esophageal cancer</b>  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 7</b> , 19 <b>82</b> , to <b>Aug 16</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Aug 16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>VINCENT K. TAM</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>Aug. 16, 1982</b>     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VINCENT K. TAM M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |   |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>8/19/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Rose</b>   |   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>York York PA</b>   |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>John H. Hopkins</b>  |  |   |  | ADDRESS<br><b>500 Main St., Delta, PA</b>   |  |   |   | 25. DATE REC'D. BY REGISTRAR<br><b>AUG 23 1982</b> REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |  |  |  |  |  |





RECEIVED

THE JAMES H. HARRIS HOSPITAL

ST. LOUIS, MO.

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THE JAMES H. HARRIS HOSPITAL

ST. LOUIS, MO.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |                             |  | 8 2 2 0 9 9 5   |  |  |  |   |  |   |   |  |  |
|---|--|---|-----------------------------|--|---|--|--|--|---|--|---|---|--|--|
| 1- FOR STATE REGISTRAR  |  |   |                             |  | REG. NO.  |  |  |  |   |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JULIA MAR WATSON</b>  |  |   |                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>AUGUST 10, 1982</b>  |  |  |  |   | 2b. HOUR<br><b>05:50PM</b>   |   |   |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>N. V</b>  |                             | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 19 19</b>                          |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                            |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN.                      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                             |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COOK</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b>   |   |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  |   |                             |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3017 She Albameda</b> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George D. Wynn</b>   |  |   |                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>7</b>   |  |  |  |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |                             |  | 16b. SOCIAL SECURITY NO.<br><b>220-01-2751</b>  |  | 17. INFORMANT ADDRESS<br><b>ALICE POLIARD 5609 Lethian Rd</b>                |  |   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b>   |  |   |                             |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>08-10-82</b>  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>8 DAYS STATUS POST AORTIC VALVE REPLACEMENT</b>  |  |   |                             |  |   |  |  |  |   | <b>08-03-82</b>  |   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>AORTIC STENOSIS</b>  |  |   |                             |  |   |  |  |  |   | <b>07-82</b>   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |   |                             |  |   |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>08-03-82</b>   |  |   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>AORTIC STENOSIS</b> |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>          |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-1</b> , 19 <b>82</b> , to <b>8-10</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8-10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |                             |  |   |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>William A. Baugartner</b>  |  |   |                             |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  |   | 22c. DATE SIGNED<br><b>8-11-82</b>   |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William A. Baugartner</b>   |  |   |                             |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |  |  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION/REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>8/11/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus mem. PK</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus MD</b>                      |   |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LOCKS FUNERAL HOME</b>   |  |   |                             |  | ADDRESS<br><b>1304 N. Central Ave</b>   |  |  |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>AUG 12 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b> |  |  |

THE JOURNAL OF THE  
SOCIETY OF AMERICAN ARCHITECTS  
JULY 1903

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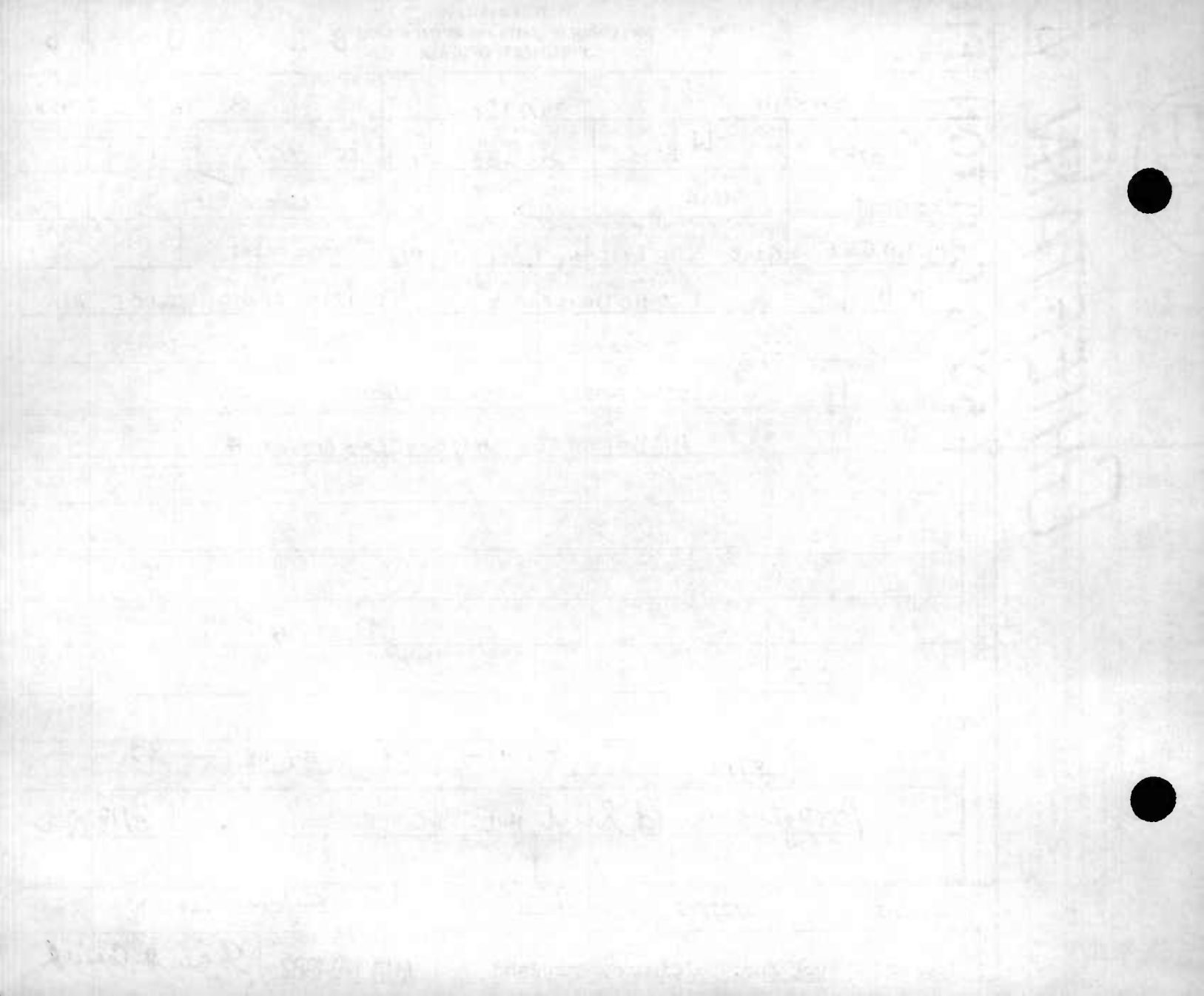
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 0 9 9 6

REG. NO.

|  |  |  |  |   |  |   |  |  |  |  |  |                                   |  |                                   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|-----------------------------------|--|-----------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>SARAH   |  | MIDDLE  |  | LAST<br>WATSON  |  | 2a. DATE OF DEATH  |  | MONTH<br>8                                   |  | DAY<br>18                         |  | YEAR<br>82                        |  | 2b. HOUR<br>7:45AM                           |  |
| 3. SEX<br>F<br>Female  |  | 4. RACE<br>W<br>White  |  | 5. DATE OF BIRTH<br>MONTH<br>8<br>DAY<br>23<br>YEAR<br>97   |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84<br>8/17<br>YRS.  |  |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS |  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City<br>MD   |  |  |  |                                   |  |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GOOD SAMARITAN, BALTIMORE |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                                   |  |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1815 RAMBLEWOOD RD.   |  |  |  |                                   |  |                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br>James<br>MIDDLE<br>Hillery<br>LAST<br>Buckmaster   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Mary<br>MIDDLE<br>LAST<br>Lowery   |  |   |  |  |  |  |  |                                   |  |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-22-8713   |  | 17. INFORMANT<br>June E Guinan  |  |   |  | ADDRESS<br>Same  |  |  |  |                                   |  |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ABDOMINAL ADENOCARCINOMA</u><br><u>1952</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |   |  |  |  |  |  |                                   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |  |  |  |  |                                   |  |                                   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                                   |  |                                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |                                   |  |                                   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |                                   |  |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> , 19 <u>82</u> , to <u>8/18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |   |  |   |  |  |  |  |  |                                   |  |                                   |  |  |  |
| 22b. SIGNATURE<br>Brajendra P. Singh M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |  |  |  |  |                                   |  |                                   |  | 22c. DATE SIGNED<br>8/18/82                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |  |   |  |  |  |  |  |                                   |  |                                   |  | 22e. ADDRESS                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>8/21/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Western   |  |   |  | 23d. LOCATION<br>Baltimore, Maryland<br>STATE  |  |  |  |                                   |  |                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland  |  |  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 19 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver |  |                                   |  |                                   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 0 9 9 7  
REG. NO.

|  |  |   |   |  |  |  |   |  |   |   |  |
|--|--|---|---|--|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLEVELAND WATTS</b>                   |  |   | 2a. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>4</b> YEAR <b>82</b> |  |  | 2b. HOUR <b>8:02</b> AM  |   |  |   |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>B</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>8</b> YEAR <b>04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS                             |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |   | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MASS.</b>                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                      |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>—</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b> |   |  |
| 13a. STATE<br><b>MD.</b>   |  |   | 13b. COUNTY<br><b>BALTO</b>                                     |  | 13c. CITY OR TOWN<br><b>BALTO</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>32 N. MOUNT ST.</b> |   |  |
| 14. FATHER'S NAME<br>FIRST <b>WILLIE</b> MIDDLE <b>WEBSTER</b> LAST <b>—</b> |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ALLIE</b> MIDDLE <b>?</b> LAST <b>—</b> |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)         |  |   | 16b. SOCIAL SECURITY NO.<br><b>214032346</b>                    |  |  | 17. INFORMANT<br>ADDRESS<br><b>DR. H. COHEN</b>                              |   |  |   |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIO-RESPIRATORY ARREST**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **SQUAMOUS CELL CARCINOMA (LUNG)**

DUE TO, OR AS A CONSEQUENCE OF

(c) **—**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**DEHYDRATION**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR <b>—</b> A.M. MONTH <b>—</b> DAY <b>—</b> YEAR <b>—</b><br>P.M. <b>—</b> 19 <b>—</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b> |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>                               |  | 21f. LOCATION<br>STREET <b>—</b> CITY OR TOWN <b>—</b> COUNTY <b>—</b> STATE <b>—</b>      |  |  |  |
| 22a. I certify that <b>—</b> this hospital attended the deceased from <b>7/30</b> 19 <b>82</b> to <b>8/4</b> 19 <b>82</b> that <b>—</b><br>saw the deceased alive on <b>8/4</b> 19 <b>82</b> and that in <b>—</b> (my) opinion death occurred on the date and hour and from the causes stated above. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Howard B. Cohen, M.D.</b>   |  |  |  | DEGREE<br><b>—</b>   |  | 22c. DATE SIGNED<br><b>8/4/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HOWARD B. COHEN, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>BON SECOURS HOSP.</b>   |  |  |  |

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                |  | 23b. DATE<br><b>8-11-82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MITZION</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO</b> COUNTY <b>MD.</b> STATE <b>—</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>BROWN THOMPSON</b> ADDRESS <b>1915 N. BALTO</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE<br><b>AUG 18 1982</b> <b>John J. Carver</b> |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

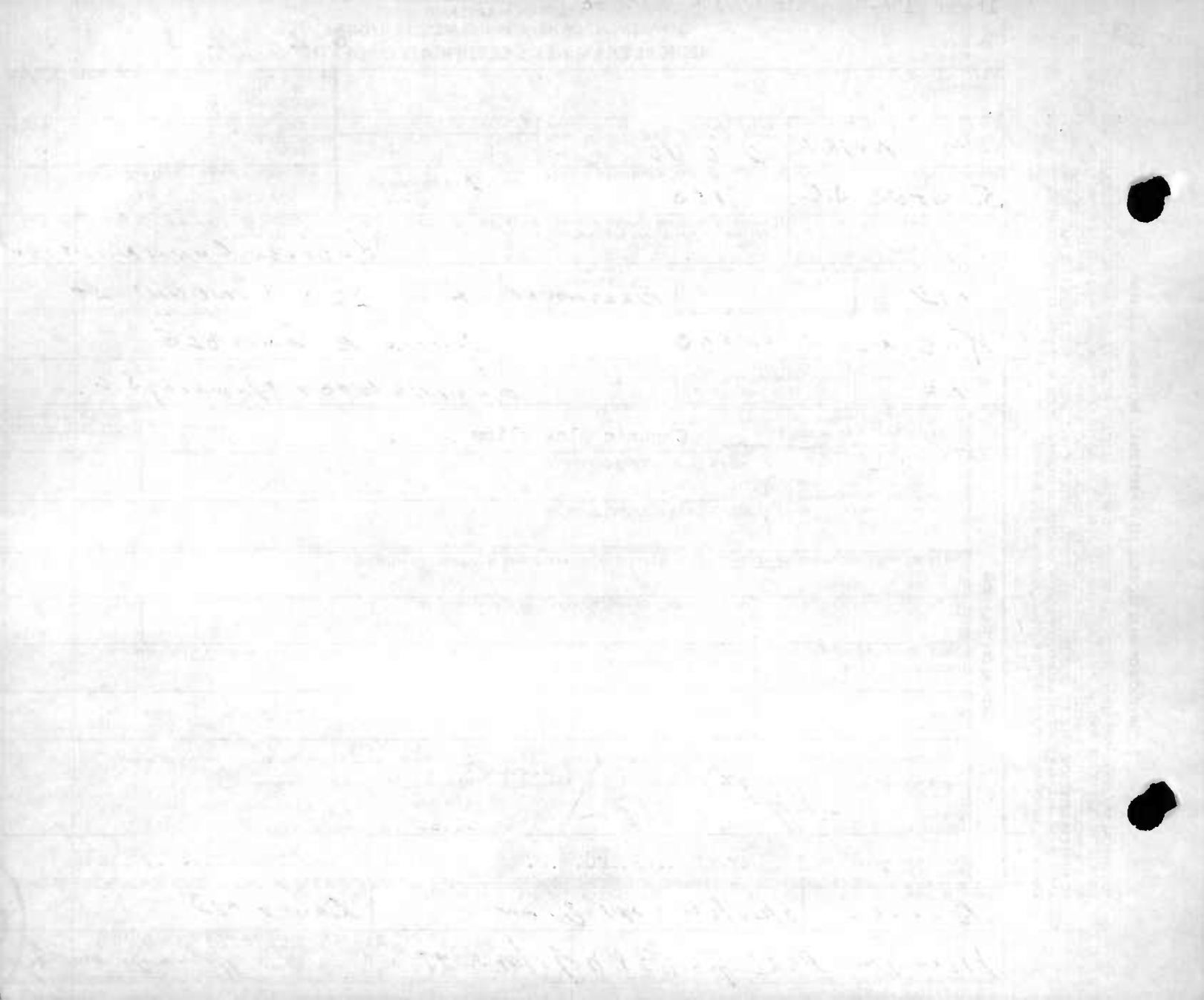
## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 0 9 9 8<br>REG. NO.  |  |                                   |  |
|--|--|--|--|---|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ROBERT LEROY WATTS  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 1 82   |  |   |  | 2b. HOUR<br>9:28P M  |  |                                   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 08 33  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC LOCH RAVEN BLVD. BALTO. MD |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BACKHOE SERVICES            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SELF-EMPLOYED   |  |                                   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>RELAY  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1732 ARLINGTON AVENUE, 21227  |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES W. WATTS   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ESTELLA JACOBS   |  |   |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>KOREAN 215-30-8064  |  | 17. INFORMANT<br>ESTELLA J. WATTS   |  |   |  | ADDRESS<br>1732 ARLINGTON AVENUE   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>1850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Probable Hyperkalemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Pancreatic Carcinoma/Hepatoportal failure</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVING RISE TO PART 1.   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                                   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 30</u> , 19 <u>82</u> , to <u>August 1</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <u>August 1</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |  |  |   |  |   |  |  |  |                                   |  |
| 22b. SIGNATURE<br><u>T. Pallone</u>  |  |  |  | DEGREE<br><u>MD</u>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>8/2/82</u> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T. PALLONE  |  |  |  | 22e. ADDRESS<br>3900 Loch Raven Blvd. Balto. Md 21218   |  |   |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>08-05-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE MEM. PK.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ELKRIDGE HOWARD MARYLAND                          |  |  |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229   |  |  |  | 25a. DATE REGD. BY REGISTRAR<br>AUG - 5 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. [Signature]</u>                                       |  |  |  |                                   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED: WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND; 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |   |   |   |                               |  |  |   |  | REG. NO. 20999                               |  |
|---|----------------------|---|---|---|-------------------------------|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |                      |   |   |   |                               |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>David Webb</b>   |                      |   |   |   |                               | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 15 1982</b> |  | 2b. HOUR <b>4:05 PM</b>   |  |  |  |
| 3. SEX <b>M</b>   | 4. RACE <b>NEGRO</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 6 46</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>36</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>8 19 1982</b>  |  | 2d. HOUR <b>4:05 PM</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SUMTER S.C.</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>22 N. Vincent Street</b> |   |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Abbecon Construction</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE <b>MD</b>  |                      | 13b. COUNTY <b>Baltimore</b>  |   | 13c. CITY OR TOWN <b>Baltimore</b>  |                               | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | 13e. STREET ADDRESS<br><b>22 N VINCENT ST</b>                                       |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>ROBINSON WEBB</b>   |                      |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>EDNA R GAMBLES</b>   |                               |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>   |                      |   |   | 16b. SOCIAL SECURITY NO.  |                               | 17. INFORMANT<br>ADDRESS<br><b>4416 WOOD MANNING S.C.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Chronic Alcoholism</b>  |                      |   |   |   |                               |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <b>3030</b><br>DUE TO, OR AS A CONSEQUENCE OF   |                      |   |   |   |                               |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                      |   |   |   |                               |  |  |   |  |  |  |
| (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                      |   |   |   |                               |  |  |   |  |  |  |
| (c) _____   |                      |   |   |   |                               |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                      |   |   |   |                               |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                      |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                               |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                            |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |   |   |   |                               |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b>   |                      |   |   | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER   |                               |  |  | DATE SIGNED <b>8/20/82</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |                      |   |   | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>   |                               |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                      | 23b. DATE<br><b>8/24/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD 3-44</b>  |                               |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Marlene Phillips 638 N. G. Street</b>  |                      |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 1 1982</b>  |                               | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   | 8 2 2 1 0 0 0<br>REG. NO.  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>AGNES E. WEIDNER   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 15 1982<br>2b. HOUR<br>7:30 PM   |   |  |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 17 1918  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SELF                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN KRASKI  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELIZABETH KRYGER   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>212-03-2134  |  | 17. INFORMANT ADDRESS<br>EDWARD J. WEIDNER (SAME)   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Suggestive heart failure<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF ASHD. Lx of myocardial infarction<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                       |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>R. Sayadi M.D.  |  |  |  |   | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>8/16/82                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. Sayadi  |  |  |  |   | 22e. ADDRESS<br>CH.  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br>BURIAL  |  | 23b. DATE<br>8/19/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART OF JESUS   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD                                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SKARDA FUNERAL HOME   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 23 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |  |  |

20% COTTON

WASHABLE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove card for Robert L. Weisman, filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |  |  | 8 2 2 1 0 0 1                                |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.   |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT W. WEISMAN</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>AUGUST 27, 1982</b>   |  |  |  | 2b. HOUR<br><b>05:05AM</b>   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 22, 1955</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>26</b> YRS.                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Pilot</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Atlantic Air, Inc.</b>   |  |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Anne Arundel</b> 13c. CITY OR TOWN <b>Linthicum</b>   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>504 Darlene Avenue, 21090</b>                              |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert L. Weisman</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>B. Barbara M. Weller</b>   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-70-2345</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Robert L. Weisman Same as Above (#13)</b>   |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>1869</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Testicular cancer - metastatic to lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>26 August</b> , 19 <b>82</b> , to <b>27 August</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>27 August</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>A. Freifeld</b>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED<br><b>8/27/82</b>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. FREIFELD</b>   |  |  |  |   | 22e. ADDRESS<br><b>601 N. Broadway</b>   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b. DATE<br><b>8/30/1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Ph.</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A. A. Co., Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McQuilly Funeral Homes</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>237 E. Patapsco Ave., Balto., Md., 21225</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>AUG 30 1982</b>                                     |  | 25c. REGISTRAR'S SIGNATURE<br><b>John J. Gwinn</b>   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 1 0 0 2<br>REG. NO.   |  |   |  |   |  |                                    |  |
|---|--|---|--|---|--|---|--|---|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>IRENE WEITZMAN</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 31 82</b>   |  |   |  | 2b. HOUR<br><b>8:50 P.M.</b>  |  |                                    |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC. 2, 1908</b>   |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>73</b>                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |  |   |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF OCCUPATION OR WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRIS</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELSIE GASKEL</b>  |  |   |  | 13e. STREET ADDRESS<br><b>5818 GREENSPRING AVE. 21215</b>   |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-05-3566</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>REUBEN WEITZMAN</b>  |  |   |  | 5818 GREENSPRING AVE., BALTO., MD 21215   |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE ANTERIOR MI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>A. S. C. V. D.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>4100</b> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b>  |  |                                    |  |
|   |  |   |  |   |  |   |  | <b>12 hrs</b>   |  |                                    |  |
|   |  |   |  |   |  |   |  | <b>20 yrs</b>   |  |                                    |  |
|   |  |   |  |   |  |   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |                                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  | 22b. SIGNATURE<br><b>Eduardo Anhalt</b>   |  | 22c. DATE SIGNED<br><b>8.31.82</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDUARDO ANHALT</b>  |  |   |  | 22e. ADDRESS<br><b>Sinai Hospital</b>   |  |   |  |   |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>SEPT. 2, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMUNO</b>   |  | 23d. LOCATION<br>CITY TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>              |  |   |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 8 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                                |  |   |  |                                    |  |

WESTERN

STANDARD

WESTERN

1918

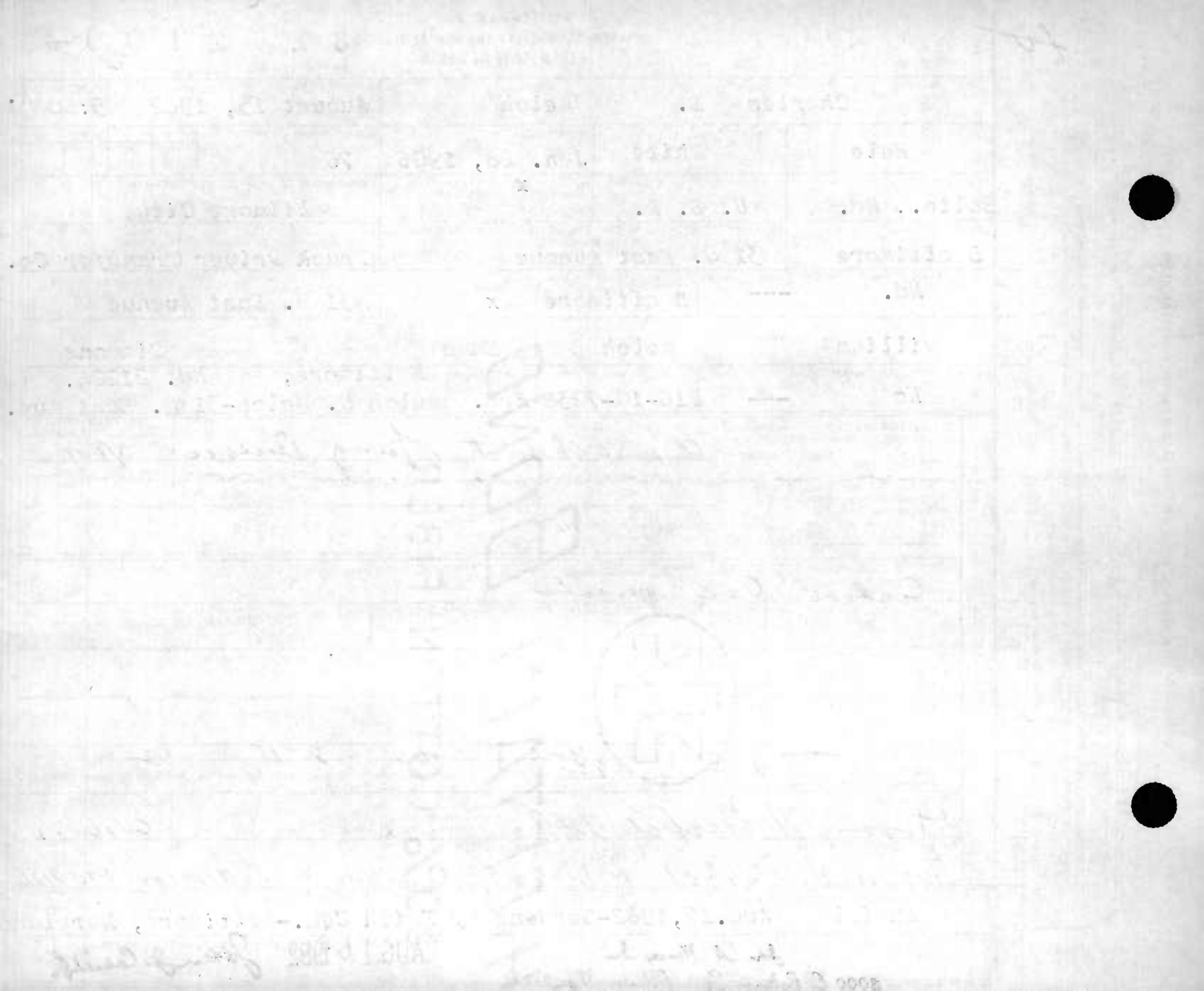
STANDARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Charles E. Welch</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 15, 1982</b>  |  | 2b. HOUR<br>M<br><b>5:00 A.</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 28, 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>31 S. East Avenue</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver Transfer Co.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>--</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>31 S. East Avenue</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Welch</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Simmons</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |  | 17. INFORMANT <b>Baltimore, Md. 21224.</b><br><b>Mrs. Beulah L. Welch-31 S. East Ave.</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4960</b> IMMEDIATE CAUSE (a) <b>Chronic Obstructive Lung Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Year.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Cordis Decompression</b>   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-6</b> , 19 <b>66</b> , to <b>8-11</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8-3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>John H. Goskel MD.</b>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>8-16-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John H. Goskel MD.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>6375 Conkling St Baltimore, Md 21224</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Aug. 17, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.-Baltimore, Maryland</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John A. Moran D.D.S.</b>   |  |   |  |   |  | 25. DATE RECEIVED BY REGISTRAR<br><b>AUG 16 1982</b>   |  |   |  |
| 26. ADDRESS<br><b>3000 E. Baltimore St. Baltimore, Md 21224</b>   |  |   |  |   |  | 27. REGISTRAR'S SIGNATURE<br><b>John J. Casper</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

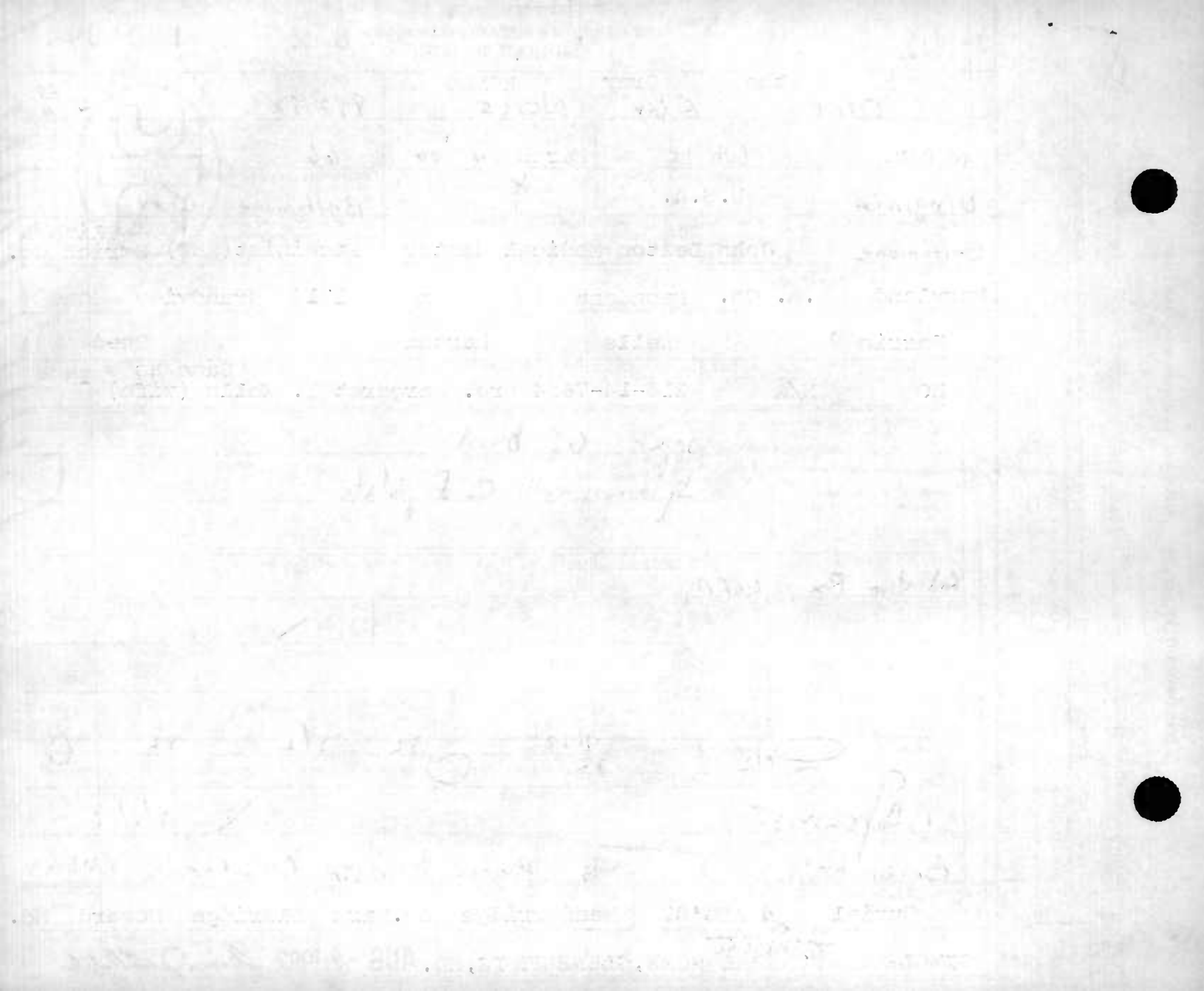
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |   |   |  |                                   |  |
|---|--|--|--|---|---|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 8 2 2 1 0 0 4   |   |  |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |   | 2a. DATE OF DEATH   |   |  |                                   |  |
| FIRST MIDDLE LAST<br>Otho Gray WELLS<br>Otho GRAY WELLS   |  |  |  |   | MONTH DAY YEAR<br>8/2/82  |   |  |                                   |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH  |   | 6 AGE (IN YEARS LAST BIRTHDAY)                                |  | 2b. HOUR                          |  |
| male  |  | White  |  | MONTH DAY YEAR<br>March 14 '16  |   | 66 YRS  |  | 4 20 AM                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                           |  |                                   |  |
| Virginia  |  | U.S.A.   |  |   |   | Baltimore City MD   |  |                                   |  |
| 11. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore   |  | John Deaton Medical Center   |  |   |   | Machinist (RET)   |  | Flinn & Emrich Co.                |  |
| 13a. STATE  |  |  |  |   | 13b. CITY OR TOWN   |   | 13c. STREET ADDRESS  |                                   |  |
| Maryland  |  |  |  |   | A.A. Co.  |   | Pasadena   |                                   |  |
| 14. FATHER'S NAME   |  |  |  |   | 15. MOTHER'S MAIDEN NAME  |   |  |                                   |  |
| FIRST MIDDLE LAST<br>Parris Wells   |  |  |  |   | FIRST MIDDLE LAST<br>Martha Reed                                    |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |                                   |  |
| NO  |  |  |  |   | N/A   |   | Same as # 13   |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |   |  |                                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |   |   |  |                                   |  |
| 1850 IMMEDIATE CAUSE (a) Upper GI bleed   |  |  |  |   |   |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |   | (b) Squamous cell Ca of palate                                      |   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   | (c)   |   |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |   |  |                                   |  |
| Radiation Rx, COPD  |  |  |  |   |   |   |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|   |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |   |   |  |                                   |  |
|   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |   |   |  |                                   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |   |   |  |                                   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | CITY OR TOWN COUNTY STATE   |   |   |  |                                   |  |
| 22a. I certify that (I) this hospital attended the deceased from 8/2 to 8/2, 1982, that (I) we lost   |  |  |  |   |   |   |  |                                   |  |
| saw the deceased alive on 8/2, 1982, and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |                                   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   | 22c. DATE SIGNED  |  |                                   |  |
| B. Deaton MD  |  |  |  |   |   | 8/2/82  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |   |   |  |                                   |  |
| Brian Deaton MD   |  |  |  | Deaton Medical Center 611 S Charles Baltimore   |   |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION   |  |                                   |  |
| Burial  |  | 4 AUG '82  |  | Meadowridge Mem. Park   |   | CITY OR TOWN COUNTY STATE<br>Elkridge Howard Md.              |  |                                   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                                    |  |                                   |  |
| SINGLETON FUNERAL HOME, GLENBURIE, MD.  |  |  |  | AUG - 3 1982  |   | Thane Jan. Nathan   |  |                                   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 2 1 0 0 5   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Arthur Wenner</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>August 16, 1982</b>  |  |  |  |
| 2b. HOUR<br><b>4:30 p.m.</b>  |  |   |  |   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 17, 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Operator of Garage</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Penn.</b> 13b. COUNTY <b>Luzerne</b> 13c. CITY OR TOWN <b>Conyngham</b>  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alfred C. Wenner</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Kropp</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>174-28-3458</b>  |  | 17. INFORMANT<br><b>Mr. David Wenner</b><br><b>Belair, MD.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: <b>1629 Congestive Heart Failure</b>   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>two weeks</b>   |  |
| IMMEDIATE CAUSE (a) <b>Squamous Carcinoma Left Lung</b>   |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <b>XXX</b> (the <input checked="" type="checkbox"/> hospital) attended the deceased from <b>August 3</b> , 19 <b>82</b> , to <b>August 16</b> , 19 <b>82</b> , that <b>X</b> (we) lost saw the deceased alive on <b>August 16</b> , 19 <b>82</b> , and that in <b>XXX</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>X</b> (we) (did) <b>not</b> view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert Liberto</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>8/16/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT LIBERTO</b>  |  |   |  | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY <b>Burial</b>  |  | 23b. DATE<br><b>8-27-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Johns Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Butler Township, Luzerne Penn.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Road Randallstown, Maryland</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>21183 AUG 20 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canick</b>  |  |

4330

August 15, 1963

Woman

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |   |  | 8 2 2 1 0 0 6 |
|---|--|---|--|---|--|--|--|---|--|---------------|
| 1 - FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |  |  |   |  |               |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST <i>Marie</i> MIDDLE <i>E.</i> LAST <i>West</i>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>8 26 82</i> |  |  | 2b. HOUR<br><i>515p</i>   |  |               |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>11 14 04</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>77</i>   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.                               |  |   |  |               |
| 10. CITY OR TOWN OF DEATH<br><i>Balto</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Balto. City Hospitals Chronic Facility</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Housework</i>   |  |               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>416 Cornwall Street</i>   |  |               |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Herman</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Magdalena Wolf</i>   |  |   |  |  |  |   |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>212-74-3043</i>  |  | 17. INFORMANT ADDRESS<br><i>Paul P. West 416 Cornwall Street 21224</i>  |  |  |  |   |  |               |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><i>2500</i> IMMEDIATE CAUSE (a) <i>Respiratory arrest -</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetes mellitus - ASCVD</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 min</i><br><i>many years</i>                                       |  |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>  |  |   |  |   |  |  |  |   |  |               |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |               |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |               |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 18</i> , 19 <i>80</i> , to <i>August 26</i> , 19 <i>82</i> , that (I) (we) lost the deceased alive on <i>August 26</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |               |
| 22b. SIGNATURE<br><i>Rise M. Chart MD</i>   |  |   |  | DEGREE  |  |  |  | 22c. DATE SIGNED<br><i>8/26/82</i>  |  |               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Rise M. Chart</i>   |  |   |  | 22e. ADDRESS<br><i>Dept of Internal Med. Balto. City Hospital</i>   |  |  |  |   |  |               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>8-30-82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Sacred Heart Cem.</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Dundalk Balto. Co. Md.</i>                     |  |   |  |               |
| 24. FUNERAL DIRECTOR<br><i>C.S. Zeiler &amp; Son Inc. 6224 Eastern Avenue</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>AUG 27 1982</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>  |  |   |  |               |

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation  
Washington, D. C.

Dear Sir:

I am writing to you regarding the matter of the

recently received information concerning the

activities of the group known as the

Internal Security - Communist Party, U. S. A.

It is requested that you advise me of the results of your

investigation of this matter.

Sincerely,  
John Doe

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 1-4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 2 1 0 0 7<br>REG. NO.   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LUCILLE WESTCOTT (Logan)   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>8 4 82 12.25 PM  |  |  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 14 23   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 7. YRS<br>58   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mexie. Texas   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE Md.  |  |   |  | 13b. COUNTY Balto.  |  | 13c. CITY OR TOWN Balto.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Oscar Allen  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Gertrude Allen  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>Warnell Alcorn 3706 Menlo Dr.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Breast with metastasis - three years</u><br>1749 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of Breast with metastasis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Hypertension, Angina, Congestive heart failure - several years</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Right hip fracture.</u> |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 7/14/82 to 8/4/82 that (one/two) last saw the deceased alive on 8/4/82 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE A. Sirithara   |  |   |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>           |  | 22c. DATE SIGNED 8/4/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. A. SIRITHARA   |  |   |  | 22e. ADDRESS UNION MEMORIAL HOSPITAL  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 8/16/82   |  | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., Md.   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>LEROY O. DYETT 4600 LIBERTY HIGTS AVE.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR AUG - 6 1982  |  |  |  |

100% COTTON FIBER





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   |  |  |   |  |  |  |
|--|--|--|---|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | REG. NO. 8 2 2 1 0 0 8   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOHN HENRY WEYER, SR.</b>   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 9 82</b>                  |  | 2b. HOUR<br><b>7:05 PM</b>  |  |  |  |
| 1. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12- 15- 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>69</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tool &amp; Die Maker</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tool &amp; Die Works</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br><b>Maryland Baltimore</b>   |  |  |   |   | 13b. CITY OR TOWN<br><b>Arbutus</b>                                |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>948 Regina Drive 21227</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Albert Knight Weyer</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Martha Hurdle</b> |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO<br><b>215-10-9578</b>  |   | 17. INFORMANT ADDRESS<br><b>Doris E. Weyer 948 Regina Drive 21227</b>   |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) Cardiac pulmonary arrest.</b>  |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCT.</b>   |  |  |   |   |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD.</b>  |  |  |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-9</b> , 19 <b>82</b> , to <b>8-9-8</b> , 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>8-9-82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Mailladomo</b>  |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8-9-82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard L. Wachtman</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>ST. Agnes Hospice Balt. Md.</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>8/13/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>   |  |  |   |   |  | 24b. ADDRESS<br><b>21229</b>   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>AUG 11 1982 John J. Carver</b>                              |  |  |



8

7:05 PM

12-15-12

WATER CITY

WATER CITY

WATER CITY

WATER CITY

WATER CITY

WATER CITY

WATER CITY



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 0 9

REG. NO.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Sophia E. Wheeler</i> |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>August 17 1982</i>             |   | 2b. HOUR<br><i>4:48 PM</i>  |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>Black</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9 21 92</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><i>89</i>               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Baltimore</i>                     | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD. |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore-</i>                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Greater Pennsylvania N.H.</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)         | 12b. KIND OF BUSINESS OR INDUSTRY                                 |   |
| 13a. STATE<br><i>Maryland</i>  |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><i>Baltimore</i>                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charles E. Johnson</i>                  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ella Noel</i>        |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No -</i>  |   | 16b. SOCIAL SECURITY NO.<br><i>216-28-1753</i>  | 17. INFORMANT<br>ADDRESS<br><i>Floyd Johnson 2302 E. Coldspring Lane</i> |   |   |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *4029 Congestive heart Failure*

DOE TO, OR AS A CONSEQUENCE OF (b) *Hypertensive heart disease*

DOE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

*Old Stroke*

MEDICAL CERTIFICATION

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-6</i> 19 <i>79</i> , to <i>8-17</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>8-17-</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><i>R. O. Crosley</i>   | DEGREE<br><i>MD</i>  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>R. O. CROSLLEY</i>   | 22e. ADDRESS<br><i>1235 E. Monument St Balto</i>                       |  |  |

|  |                             |   |  |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>                | 23b. DATE<br><i>8/20/82</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mount Auburn Cem</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Md.</i> |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm. C. March F/H 1101 E. North Avenue</i> |                             | 25a. DATE REC'D. BY REGISTRAR<br><i>AUG 19 1982</i>           |  |
|  |                             | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>           |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A) 5 ME (5)  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21010

|   |   |                        |   |                         |  |   |           |                        |   |          |  |
|---|---|------------------------|---|-------------------------|--|---|-----------|------------------------|---|----------|--|
| 1. FOR STATE REGISTRAR  |   | 2. DATE KNOWN OF DEATH |   | 3. MONTH                |  | 4. DAY  |           | 5. YEAR                |   | 6. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |   | FIRST                  |   | MIDDLE                  |  | LAST  |           | 2. DATE KNOWN OF DEATH |   | 3. MONTH |  |
| CATHERINE   |   | G.                     |   | WHETZEL                 |  | 8   |           | 10                     |   | 1982     |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH       | 6. AGE (IN YEARS)   | 7. IF UNDER 1 YR.       | 8. IF UNDER 24 HRS.  | 9. DATE PRONOUNCED DEAD   | 10. MONTH | 11. DAY                | 12. YEAR  | 13. HOUR | 14. MIN.                                     |
| Female  | White   | May 26 1967            | 75 YRS.   |                         |  | 8   | 10        | 1982                   |   | 11:45    | a  |
| 15. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 16. CITIZEN OF WHAT COUNTRY?  | 17. MARRIED            | 18. NEVER MARRIED   | 19. WIDOWED             | 20. DIVORCED   | 21. BALTIMORE CITY OR COUNTY OF DEATH   |           |                        |   |          |  |
| West Virginia   | USA   |                        |   |                         |  | Baltimore City  |           |                        |   |          |  |
| 22. CITY OR TOWN OF DEATH   | 23. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                        |   |                         | 24. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   |           |                        | 25. KIND OF BUSINESS OR INDUSTRY                                    |          |  |
| Baltimore   | University Hospital   |                        |   |                         | Chef - Retired   |   |           |                        |   |          |  |
| 26. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 27. STATE   | 28. COUNTY             | 29. CITY OR TOWN  | 30. INSIDE CITY LIMITS? | 31. STREET ADDRESS   |   |           |                        |   |          |  |
| Maryland  | AA  | Glen Burnie            | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 144 Midland Road        |  |   |           |                        |   |          |  |
| 32. FATHER'S NAME   |   |                        | 33. MOTHER'S MAIDEN NAME  |                         |  | 34. ADDRESS   |           |                        |   |          |  |
| FIRST MIDDLE LAST   |   |                        | FIRST MIDDLE LAST   |                         |  | FIRST MIDDLE LAST   |           |                        |   |          |  |
| Lloyd   |   |                        | Plum  |                         |  | Emma Sypold   |           |                        |   |          |  |
| 35. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |   |                        | 36. SOCIAL SECURITY NO.   |                         |  | 37. INFORMANT   |           |                        |   |          |  |
| No  |   |                        | 235-38-9639   |                         |  | Patrick J. McGovern, Same as 13.  |           |                        |   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |                        |   |                         |  |   |           |                        |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:   |   |                        |   |                         |  |   |           |                        |   |          |  |
| 8120 IMMEDIATE CAUSE (a) Traumatic injuries with complications  |   |                        |   |                         |  |   |           |                        |   |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |                        |   |                         |  |   |           |                        |   |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |   |                        |   |                         |  |   |           |                        |   |          |  |
| (b)   |   |                        |   |                         |  |   |           |                        |   |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |                        |   |                         |  |   |           |                        |   |          |  |
| (c)   |   |                        |   |                         |  |   |           |                        |   |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |   |                        |   |                         |  |   |           |                        |   |          |  |
| Arteriosclerotic cardiovascular disease   |   |                        |   |                         |  |   |           |                        |   |          |  |
| 19a. DATE OF OPERATION  |   |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |                         |  |   |           |                        | 20. AUTOPSY?  |          |  |
|   |   |                        |   |                         |  |   |           |                        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |  |
| 21a. EXTERNAL CAUSE   |   |                        | 21b. TIME OF INJURY   |                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |           |                        |   |          |  |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   |                        | 5:23 P.M. 6-25-1982   |                         |  | Driver in auto/bus collision.   |           |                        |   |          |  |
| 21d. INJURY OCCURRED  |   |                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |                         |  | 21f. LOCATION   |           |                        |   |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   |                        | Road  |                         |  | Rt. 648 & Rt. 270 Glen Burnie, Anne Arundel, Md                               |           |                        |   |          |  |
| 22a. I certify that I took charge of the remains described above, held on   |   |                        |   |                         |  |   |           |                        |   |          |  |
| Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |   |                        |   |                         |  |   |           |                        |   |          |  |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |   |                        |   |                         |  |   |           |                        |   |          |  |
| ACTUAL SIGNATURE  |   |                        | TITLE (SPECIFY)   |                         |  |   |           |                        | DATE SIGNED   |          |  |
| Thomas D. Smith, M.D.   |   |                        | Deputy Chief  |                         |  |   |           |                        | 8-11-82   |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |   |                        | ADDRESS   |                         |  |   |           |                        |   |          |  |
| James S. Kirkley, Glen Burnie, MD   |   |                        | 111 Penn St., Balto., Md. 21201                                     |                         |  |   |           |                        |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |   |                        | 23b. DATE   |                         |  | 23c. NAME OF CEMETERY OR CREMATORY  |           |                        | 23d. LOCATION   |          |  |
| Burial  |   |                        | 13 Aug 82   |                         |  | New Cathedral Cemetery  |           |                        | Baltimore   |          |  |
| 24. FUNERAL DIRECTOR  |   |                        | 25a. DATE REC'D. BY REGISTRAR                                       |                         |  | 25b. REGISTRAR'S SIGNATURE  |           |                        |   |          |  |
| James S. Kirkley, Glen Burnie, MD   |   |                        | AUG 12 1982   |                         |  | John J. Conner  |           |                        |   |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 1 1

REG. NO.

|  |         |  |        |  |          |   |          |          |
|--|---------|--|--------|--|----------|---|----------|----------|
| 1- FOR STATE REGISTRAR   |         | 2a. DATE OF DEATH  |        | MONTH  | DAY      | YEAR  | 2b. HOUR |          |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | FIRST  | MIDDLE | LAST   |          |   |          |          |
| Doris E White  |         |  |        |  | 08 14 82 |   |          | 240 P.M. |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (IN YEARS LAST BIRTHDAY)  |          | IF UNDER 1 YEAR   |          |          |
| Female   | Cauc.   | 3 4 22   |        | 60 YRS.  |          | MONTHS DAYS HOURS MIN.  |          |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |          |          |
| Baltimore  |         | USA  |        |  |          | Baltimore City MD.  |          |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |          |          |
| Baltimore  |         | Sinai Hospital   |        | Catalyst Res.  |          | Supervisor  |          |          |
| 13a. STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN  |          | 13d. INSIDE CITY LIMITS?  |          |          |
| Nevada   |         | COUNTY   |        | Las Vegas  |          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |          |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |        | 13e. STREET ADDRESS  |          |   |          |          |
| Leroy Hennick  |         | Caroline S. Jenkins  |        | 5441 Cabrigo Drive   |          |   |          |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT ADDRESS  |          |   |          |          |
|  |         | 214-12-3666  |        | Carolyn Macauley, 51141 Cabrigo Dr. Las Vegas, Nev. 89103  |          |   |          |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART 1. DEATH WAS CAUSED BY:   |        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |          |   |          |          |
| 7101   |         | IMMEDIATE CAUSE (a)  |        | Acute Pulmonary Edema  |          |   |          |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         | (b)  |        | Sepsis   |          |   |          |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         | DUE TO, OR AS A CONSEQUENCE OF   |        | Sclerosis of Bowel & Ischemia  |          |   |          |          |
| (c)  |         |  |        |  |          |   |          |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |         |  |        |  |          |   |          |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        | 20a. AUTOPSY?  |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |          |          |
|  |         |  |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |          | YES <input type="checkbox"/> NO <input type="checkbox"/>            |          |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |          |   |          |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)                                      |        | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |          |   |          |          |
|  |         |  |        |  |          |   |          |          |
| 22a. I certify that (I) (this hospital) attended the deceased from June 5, 19 82, to August 14, 19 82, that (I) (we) last saw the deceased alive on August 14, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |         |  |        |  |          |   |          |          |
| 22b. SIGNATURE   |         | DEGREE   |        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |          | 22c. DATE SIGNED  |          |          |
| Paul Schwartz  |         | M.D.   |        |  |          | 8/14/82   |          |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         | 22e. ADDRESS   |        |  |          |   |          |          |
| Paul Schwartz M.D.   |         | Sinai Hospital Belvedere Greenspring 21215   |        |  |          |   |          |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |          | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |          |          |
| Burial   |         | 8/18/82  |        | Moreland Memorial Pk.  |          | City of Balto., Balto., MD  |          |          |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR  |        | 25b. REGISTRAR'S SIGNATURE   |          |   |          |          |
| John C. Miller, Inc., 6415 Belair Rd.  |         | AUG 17 1982  |        | John J. Camish   |          |   |          |          |

BP

MEMORANDUM

TO : Mr. E. A. Tamm  
FROM : Mr. J. Edgar Hoover  
SUBJECT: [Illegible]

DATE: [Illegible]  
[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

2 1 0 1 2

REG. NO.

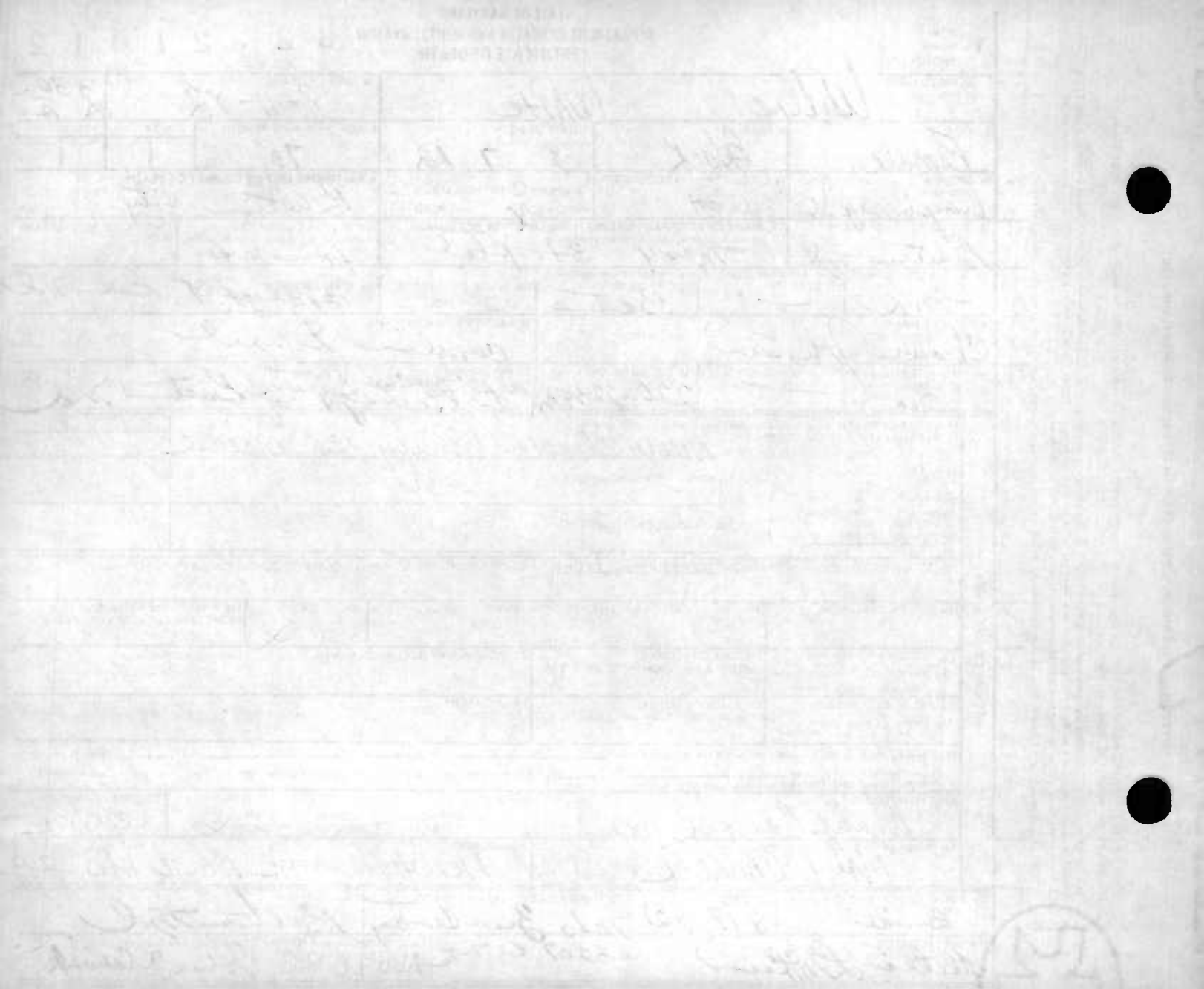
1. FOR  
STATE  
REGISTRAR

|  |  |  |   |  |                              |  |  |
|--|--|--|---|--|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Willie White</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>8-11-82</i> |  | 2b. HOUR<br><i>2:30</i> A.M. |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Black</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8 7 13</i>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington DC</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore city</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore Md</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>House wife</i>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>Md</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>  |                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 13e. STREET ADDRESS<br><i>1213 E. 8th St Baltimore Md</i>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charles Johnson</i>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Cordelia Daxel</i>   |                              | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE BRANCH AND DATES)<br><i>No</i>           |  |
| 16a. SOCIAL SECURITY NO.<br><i>220-22-9438</i>   |  | 17. INFORMANT<br>NAME ADDRESS<br><i>1213 E. 8th St Baltimore Md</i>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic Coronary Vasc. Disease</i><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: |  |  |   |  |                              |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                              | 22a. DATE SIGNED<br><i>8/11/82</i>   |  |
| 22b. SIGNATURE<br><i>Mary Carroll mo.</i> DEGREE   |  |  |   |  |                              |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MARY CARROLL</i>   |  | 22d. ADDRESS<br><i>MERCY HOSPITAL, BALTO. MD. 21202</i>  |   | 22e. DATE REC'D. BY REGISTRAR<br><i>AUG 16 1982</i>  |                              | 22f. REGISTRAR'S SIGNATURE<br><i>John J. Carroll</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>8/17/82</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt Zion Cemetery</i>  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Md</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Netha L. Brown</i>  |  | 24a. DATE REC'D. BY REGISTRAR<br><i>AUG 16 1982</i>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>John J. Carroll</i>   |                              | 24c. DATE REC'D. BY REGISTRAR<br><i>AUG 16 1982</i>  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 9 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



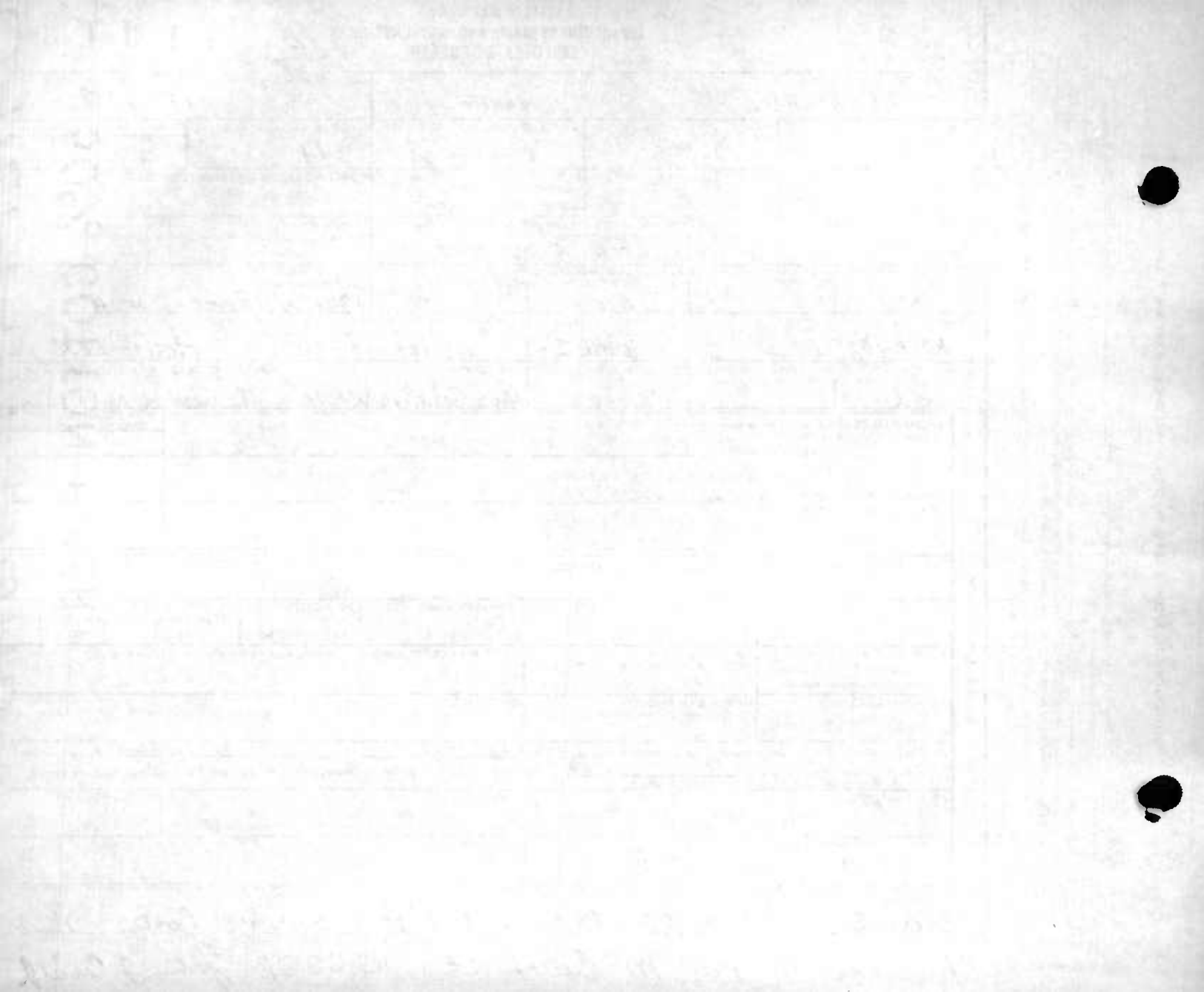
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 2 1 0 1 3  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  | 2b. HOUR  |  |  |  |
| ROLAND WHYE  |  |  |  | 8-17-82 12:03 PM  |  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  |
| MALE   |  | BLACK  |  | 5-1-68  |  | 14 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |  |
| TOPEKA, KANSAS   |  | U.S.A.   |  |   |  | CITY   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE  |  | MT. WASHINGTON PEDS HOSP.  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 1701 W. Rogers Ave   |  |
| Md   |  | BALTO  |  |   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |  |  |
| ROLAND WHYES   |  | SHARRON HARRISON   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |
| NO   |  | None   |  | Mrs Gladys Whye Towson, Md 21204  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST   |  |  |  |   |  |  |  |
| 2559   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |
| RESPIRATORY TRACT INFECTION.   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |
| ADRENOLEUKODYSTROPHY   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
|  |  | 19   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-4-75, 19, to 8-17, 1982, that (I) (we) lost saw the deceased alive on 8-17-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| Irene Oung M.D.  |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                         |  |  |  |
| IRENE OUNG. M.D.   |  |  |  |   |  |  |  |
| 22e. ADDRESS   |  |  |  |   |  |  |  |
|  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial   |  | 8/21/82  |  | Pleasant Rest   |  | Towson Balto. Md   |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Chatman F/H 1701 McCulloh St   |  |  |  | AUG 20 1982   |  | John J. Canine   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonappers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 2 2 1 0 1 4<br>REG. NO.   |  |   |  |          |
|---|--|---|--|---|--|---|--|----------|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>NORMA A WIEGAND   |  |   |  | 08-07-82  |  |   |  | 10:30 PM |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH MONTH DAY YEAR<br>4/30/26  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |  |          |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore City   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET ADDRESS<br>3710 McTavish Ave.   |  |          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Norman Murrell   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anita Simmons   |  |   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>Frederick W. Wiegand 3710 McTavish Ave.  |  |   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of Lung left with Metastasis to Liver, bones.<br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |   |  |   |  |   |  |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12, 19 82, to 8/7, 19 82, that (I) (we) last saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |          |
| 22b. SIGNATURE P. Kanani DEGREE   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED 8/8/82   |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Kanani   |  |   |  | 22e. ADDRESS  |  |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE *10/82  |  | 23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Pioletville, Baltimore, Maryland   |  |          |
| 24. FUNERAL DIRECTOR Ambrose, Inc 1328 Sulphur Spring Rd.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR AUG 09 1982   |  | 25b. REGISTRAR'S SIGNATURE John J. Caniff   |  |          |

07-51-70-





BP \_\_\_\_\_  
DHMH - 16 50M (1/81)  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

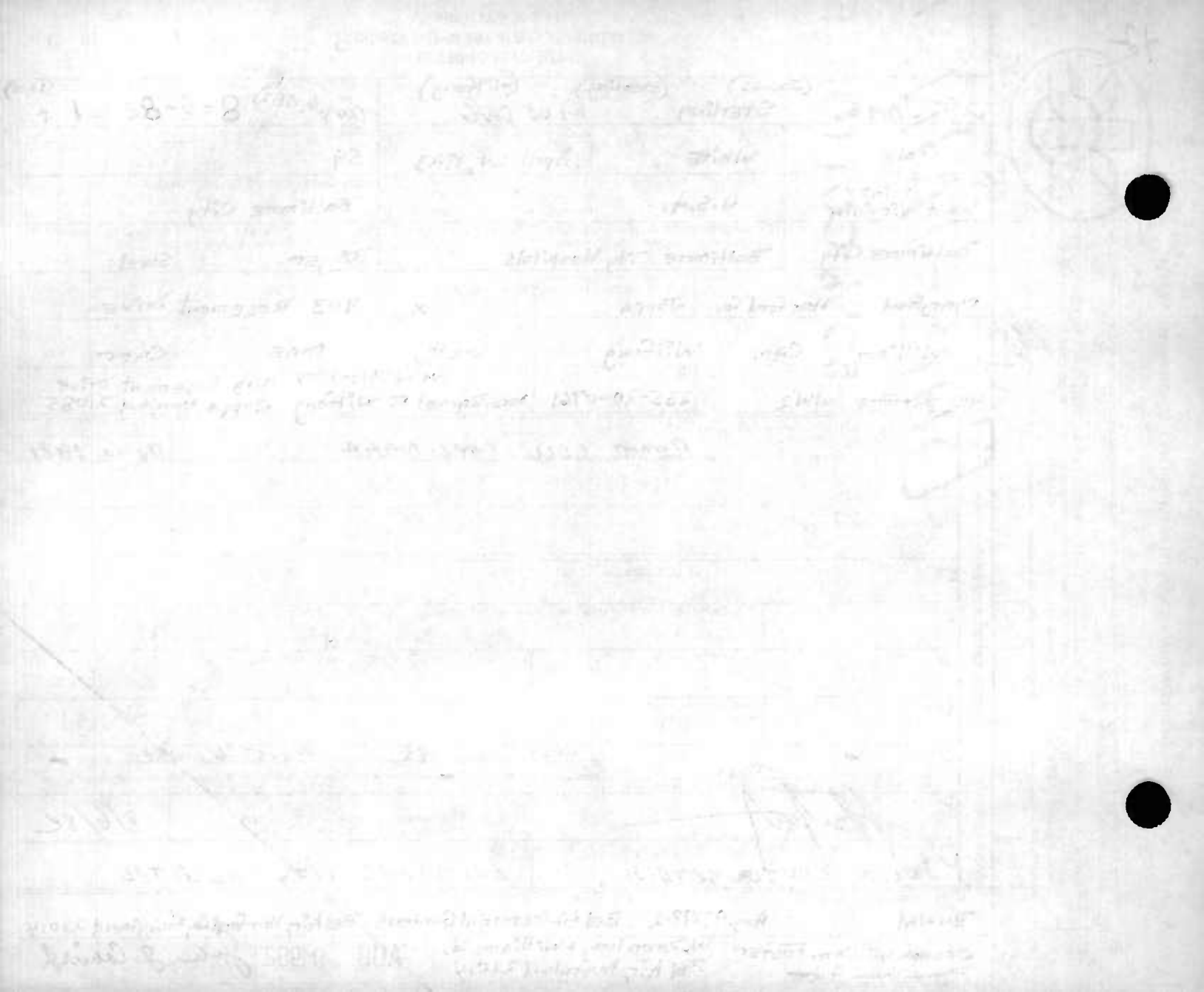
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 2 1 0 1 5   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| FIR (James) MIDDLE (Sterling) LAST (Wilfong)<br>JAMES Sterling WILFONG   |  |  |  | MONTH DAY YEAR<br>Aug. 6, 1982 8-6-82   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| MALE   |  | WHITE  |  | MONTH DAY YEAR<br>April 24, 1923  |  | 59 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| WEST VIRGINIA  |  | U.S.A.   |  |   |  | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE CITY   |  | BALTIMORE CITY HOSPITALS   |  | Rigger  |  | Steel  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. STREET ADDRESS  |  |
| Maryland   |  | Harford Co.  |  | Joppa   |  | 903 ROSEMONT DRIVE   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |
| William CAM WILFONG  |  |  |  | GETTY MAE Carr  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT (WIFE) 879-6904 ADDRESS   |  |  |  |
| YES-AIR FORCE  |  | WW2  |  | Mrs. Rachel F. Wilfong 903 ROSEMONT DRIVE Joppa, Maryland 21085   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>1890 IMMEDIATE CAUSE (a) RUPTURE COLIC CARCINOMA   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
|  |  | P.M. 19  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|  |  |  |  |   |  |  |  |
| 22. I certify that (this hospital) attended the deceased from JULY 16, 1982, to AUGUST 6, 1982, that (I) saw the deceased alive on AUGUST 5, 1982, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death. |  |  |  |   |  |  |  |
| 23a. SIGNATURE   |  |  |  | DEGREE  |  | 27c. DATE SIGNED   |  |
| JULIO LAUTON SETAN   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 8/6/82   |  |
| 23b. PHYSICIAN NAME (TYPE OR PRINT)  |  |  |  | 23c. ADDRESS  |  |  |  |
| JULIO LAUTON SETAN   |  |  |  | BALTIMORE CITY HOSPITAL   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial   |  | Aug. 9, 1982   |  | Bel Air Memorial Gardens  |  | Bel Air, Harford Co., Maryland 21014                           |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D BY REGISTRAR  |  |  |  |
| Joseph William Foster  |  |  |  | AUG 9 1982  |  |  |  |
| Widow & Williams St. Bel Air, Maryland 21014   |  |  |  | REGISTRAR'S SIGNATURE   |  |  |  |

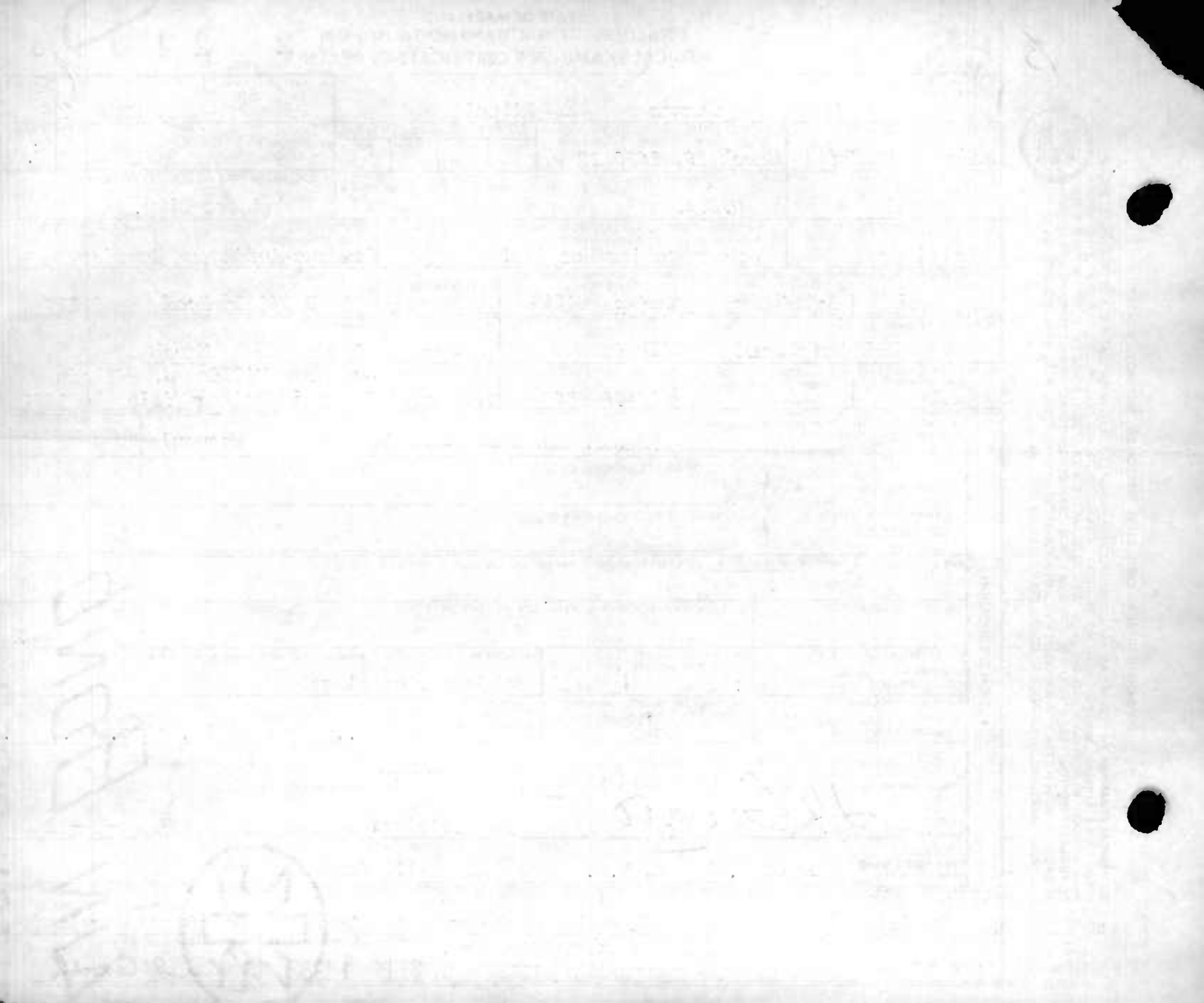




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | REG. NO. 8 2 2 1 0 1 6                             |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William Thomas Wilhoit</b>  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>            |  | MONTH DAY YEAR <b>8 28 19 82</b>   |  | 2b. HOUR <b>1:45</b> AM                            |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>March 19, 1970</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>12 YRS.</b>                                  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>8 28 19 82</b>                                 |  | 2d. HOUR <b>1:45</b> AM                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD</b>  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student-Arlington Baptist</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE <b>Maryland</b>   |  |  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Owings Mills</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>102 Dolfield Road 21117</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>William Samuel Wilhoit</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Jean Lydia Marsh</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>216-98-4652</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO. <b>216-98-4652</b>  |  |   |  | 17. INFORMANT <b>Mr. and Mrs. William S. Wilhoit</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9554</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of Head (unspecified Weapon)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>subject shot himself</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>subject shot himself</b>  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR <b>7:30</b> P.M. MONTH DAY YEAR <b>8 18 19 82</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject shot himself</b> |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>102 Dolfield Rd., Owings Mills, Balto. Co., Md.</b>  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>H.R. Guard</b>   |  |  |  | TITLE (SPECIFY) <b>Assistant</b>   |  |   |  | DATE SIGNED <b>8-29-82</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |  |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  |  | 23b. DATE <b>8-31-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers</b> ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 1 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                              |  |                            |  |  |                                 |                                      |  | 8 2 21017  |  |  |                  |  |  |  |  |  |  |
|--|--|------------------------------|--|----------------------------|--|--|---------------------------------|--------------------------------------|--|--|--|--|------------------|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |                              |  |                            | REG. NO.   |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |                              |  |                            | 2a. DATE OF DEATH  |  |                                 |                                      |  | 2b. HOUR   |  |  |                  |  |  |  |  |  |  |
| FIRST MIDDLE LAST<br>DORA WILLIAMS   |  |                              |  |                            | MONTH DAY YEAR<br>8 15 82  |  |                                 |                                      |  | 10 10 M  |  |  |                  |  |  |  |  |  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH           |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) |                                      |  | IF UNDER 1 YEAR  |  |  | IF UNDER 24 HRS. |  |  |  |  |  |  |
| F  |  | B                            |  | MONTH DAY YEAR<br>07 08 08 |  |  | 74 YRS.                         |                                      |  | MONTHS DAYS  |  |  | HOURS MIN.       |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  |                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |                  |  |  |  |  |  |  |
| 70 NC. CAROLINA  |  | USA                          |  |                            |  |  |                                 | BALTO. CITY MD.                      |  |  |  |  |                  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  |                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |                                 |                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |  |
| 37 BALTO.  |  |                              |  |                            | MERCY HOSPITAL   |  |                                 |                                      |  | HOMEMAKER  |  |  |                  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |  |                            | 13b. CITY OR TOWN  |  |                                 |                                      |  | 13d. INSIDE CITY LIMITS?   |  |  |                  |  | 13e. STREET ADDRESS  |  |  |  |  |
| 35 MD.   |  |                              |  |                            | BALTO.   |  |                                 |                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  |                  |  | 1623 W. Mulberry St  |  |  |  |  |
| 14. FATHER'S NAME  |  |                              |  |                            | 15. MOTHER'S MAIDEN NAME   |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| 300 JOE MIDDLE LAST<br>DIXON   |  |                              |  |                            | MARY MIDDLE LAST<br>GRAY   |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                              |  |                            | 16b. SOCIAL SECURITY NO.   |  |                                 |                                      |  | 17. INFORMANT  |  |  |                  |  | ADDRESS  |  |  |  |  |
| 1 No   |  |                              |  |                            | N/A  |  |                                 |                                      |  | Jennie L. Watkins  |  |  |                  |  | 1623 W. Mulberry St  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |                              |  |                            |  |  |                                 |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |  |                  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 3030 URINARY TRACT INFECTION   |  |                              |  |                            |  |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL FAILURE   |  |                              |  |                            |  |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |                              |  |                            |  |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ALCOHOL ABUSE / MALNUTRITION  |  |                              |  |                            |  |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |                            |  |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| CHRONIC HEPATITS, SIDEROBLASTIC ANEMIA   |  |                              |  |                            |  |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                              |  |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                 |                                      |  | 20a. AUTOPSY?  |  |  |                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |
|  |  |                              |  |                            |  |  |                                 |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |                  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  |                            | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                                 |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                  |  |  |  |  |  |  |
|  |  |                              |  |                            | P.M. 19  |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                              |  |                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                                 |                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |                  |  |  |  |  |  |  |
|  |  |                              |  |                            |  |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/15/82, 1982, to 8/15/82, 1982, that (I) (we) last saw the deceased alive on 8/15/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                              |  |                            |  |  |                                 |                                      |  |  |  |  |                  |  |  |  |  |  |  |
| 22b. SIGNATURE Mary Carroll MD. DEGREE   |  |                              |  |                            |  |  |                                 |                                      |  | 22c. DATE SIGNED 8/15/82   |  |  |                  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY CARROLL MD.   |  |                              |  |                            |  |  |                                 |                                      |  | 22e. ADDRESS MERCY HOSPITAL, BALTO. MD. 21202                                  |  |  |                  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              |  |                            | 23b. DATE  |  |                                 |                                      |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |  |  |  |
| BURIAL   |  |                              |  |                            | 8/20/82  |  |                                 |                                      |  | Balto. Cemetery  |  |  |                  |  | Baltimore, MD.   |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue ADDRESS  |  |                              |  |                            |  |  |                                 |                                      |  | 25a. DATE REC'D. BY REGISTRAR AUG 16 1982                                      |  |  |                  |  | 25b. REGISTRAR'S SIGNATURE John J. Conner                      |  |  |  |  |

RECEIVED  
FEB 10 1964



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MAR. 20, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  | REG. NO. 21018   |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN L. WILLIAMS   |  |  |  |  |  |  |  |   |  | 2b. HOUR <input type="checkbox"/> M <input type="checkbox"/> PM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 9 25   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.   |  | 7. IF UNDER 1 YR. MONTHS DAYS   |  | 7c. DATE PRONOUNCED DEAD<br>8-16-82  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                                       |  | 2d. HOUR<br>9:35A   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |  |  |   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3027 Rosalind Avenue   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Williams  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Alice Williams                                 |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>231-20-8014  |  | 17. INFORMANT ADDRESS<br>Irma Williams 3027 Rosalind Avenue                                  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cranio-cervical injuries</u><br>8880<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>2:15AM 8-11-82  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject fell striking head |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3000blk. Thorndale Avenue Baltimore, Maryland          |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Koroll</i>   |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |  |  | DATE SIGNED<br>8-18-82  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Koroll, M.D.   |  |  |  | ADDRESS<br>111 Penn Street   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |  | 23b. DATE<br>8/21/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Cemetery                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus Md.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 E. North Avenue   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 19 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 1 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |                 |  |   |   |   |
|--|-----------------|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHNNY P. WILLIAMS   |                 |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 28 82  |   | 2b. HOUR<br>M   |
| 3 SEX<br>MALE  | 4 RACE<br>BLACK | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 1 26  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>US   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |   |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE 12b. COUNTY 12c. CITY OR TOWN<br>MARYLAND Balt BALTIMORE  |                 |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13b. STREET ADDRESS<br>1519 KING WILLIAM DRIVE          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ARTHUR WILLIAMS  |                 | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>MINNIE HASSELL  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES  |                 | 16b. SOCIAL SECURITY NO.<br>243-40-5658  |   | 17. INFORMANT<br>ADDRESS<br>ADDIE WILLIAMS 1519 KING WILLIAM DRIVE  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) (In hospital) Acute M.I.<br>DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease 10 yrs<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                 |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                 |  |   |   |   |
| 19a. DATE OF OPERATION   |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                 |  |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/1/82 to present, 19____, that (I) (we) last saw the deceased alive on 8/30/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                 |  |   |   |   |
| 22b. SIGNATURE<br>E. L. Phillips   |                 | DEGREE<br>M.D. ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>8/30/82   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elijah Saunders, M. D.  |                 | 22e. ADDRESS<br>2 Hamill Rd. Balto., Md. 21210   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>REMOVAL  |                 | 23b. DATE<br>8-31-82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HASSELL CEMETERY  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WILLIAMSTON N. CAROLINA  |                 |  |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>E.L. PHILLIPS  |                 | 1721 N. MONROE ST.   |   | 25a. DATE RECD. BY REGISTRAR<br>AUG 30 1982   |   |
|  |                 | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 is marked, a medical examiner, or other traumatic event, then medical examination is required.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|   |  |  |  |                           |  |
|---|--|--|--|---------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | MONTH DAY YEAR   |  | HOUR MIN.                 |  |
| Leonard Max Williams  |  | 8-10-82  |  | 6:40 A.M.                 |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                | 8. IF UNDER 1 YEAR        |  |
| Male  | White  | July 9, 1911   | 71   | IF UNDER 24 HRS.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                           |  |
| Helper, Utah  | U. S. A.   |  | Baltimore City, MD.  |                           |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                           |  |
| Baltimore   | St. Agnes Hospital   | G.M. Executive   | Diesel-Loco Mfg.   |                           |  |
| 13a. STATE  | 13b. CITY OR TOWN  | 13c. STREET ADDRESS  |  |                           |  |
| Md.   | Baltimore  | 1909 Rollingwood Road  |  |                           |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   |  |  |                           |  |
| Newton A. Williams  | Louise Chittum   |  |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  |  |                           |  |
| No  | 521-03-4714  | 1909 Rollingwood Road-Catonsville, Md.   |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |                           |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |                           |  |
| 4100 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest  |  |  |  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Anterior myocardial infarction   |  |  |  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |                           |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                           |  |
|   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                           |  |
|   | P.M. 19  |  |  |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |                           |  |
|   |  |  |  |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-29-82 to 8-10-82, that (I) (we) last saw the deceased alive on 8-10-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |                           |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED          |  |
| [Signature]   |  |  |  | 8-10-82                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |                           |  |
| R. WACHADO, M.D.  |  | St Agnes Hospital BALT. MD.  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |                           |  |
| Burial  | Aug. 13, 1982  | Dulaney Valley   | Timonium, Balto., Md.  |                           |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25. DATE REC'D. BY REGISTRAR   |  | 26. REGISTRAR'S SIGNATURE |  |
| Sterling Funeral Home, 736 Edmondson Ave., Catonsville, MD 21228  |  | AUG 10 1982  |  | John J. Connel            |  |

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 2 2 1 0 2 1

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LESLIE RAYFIELD WILLIAMS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 14 82</b>                |  | 2b. HOUR<br><b>7:11P</b> M   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 21 18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WALLACE NC</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC</b>                                    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>                                      | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mike Williams</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETHEL Bryant</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR RESERVE)<br><b>244 18 5197</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Rebecca Williams 3900 Edmondson Ave</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5789</b> IMMEDIATE CAUSE (a) <b>exsanguinating lower GI hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><b>chronic obstructive pulmonary disease cor pulmonale</b>  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>AUGUST 9, 1982</b> , to <b>AUGUST 14, 1982</b> , that <b>X</b> (we) last saw the deceased alive on <b>AUGUST 14, 1982</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Rebecca Hornesack MD</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>8/15/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Balto., Md. 21218</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8-19-82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD VETERANS CEMETERY</b>    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MD</b>  |
| 24. FUNERAL DIRECTOR<br><b>MA 4404 638 NC. Mon 84</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 16 1982</b>                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |

RECEIVED  
JULY 10 1910  
PLANT INDUSTRY  
WASHINGTON, D. C.  
TO THE DIRECTOR  
FROM THE  
PLANT INDUSTRY  
WASHINGTON, D. C.  
JULY 10 1910  
PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
WASHINGTON, D. C.  
JULY 10 1910  
PLANT INDUSTRY  
WASHINGTON, D. C.  
JULY 10 1910  
PLANT INDUSTRY  
WASHINGTON, D. C.



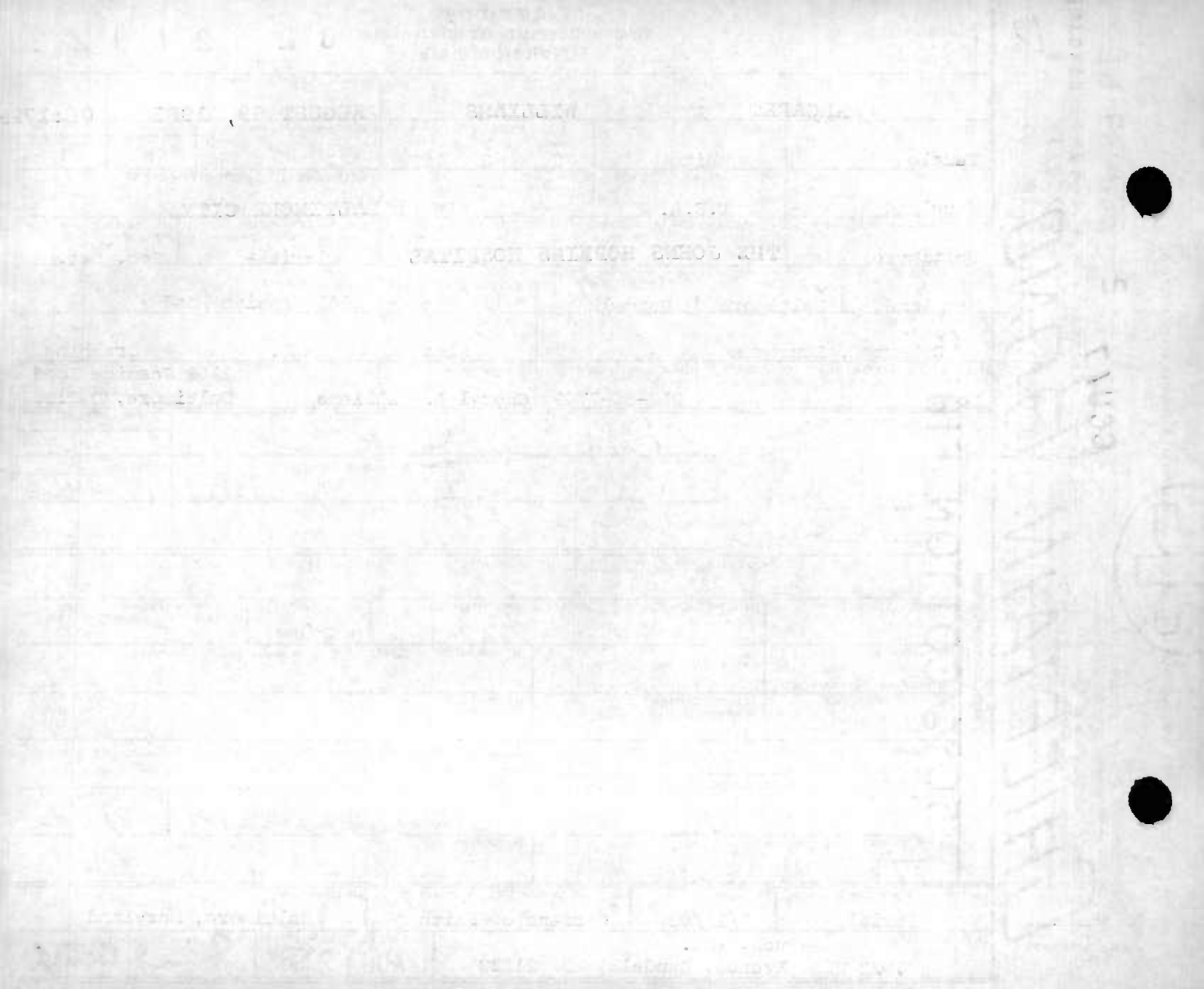
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 2 2

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 2 2 1 0 2 2  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |
| MARGARET LYNN WILLIAMS  |  |  |  | AUGUST 09, 1982  |  | 06:17 PM  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| Female  |  | White  |  | MONTH DAY YEAR<br>2 2 1939   |  | 43 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Maryland  |  | U.S.A.   |  |  |  | BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore   |  | THE JOHNS HOPKINS HOSPITAL   |  | Clerical   |  | Soc. Sec.   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| Maryland  |  | Baltimore  |  | Dundalk  |  | 13e. STREET ADDRESS   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 17. INFORMANT   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |  |  | ADDRESS   |  |
| Robert C. Sturgeon  |  | Alma L. Crabbin  |  |  |  | 2103 Jasmine Road   |  |
| 18a. SOCIAL SECURITY NO.  |  | 18b. SOCIAL SECURITY NO.   |  | 19. CHRYSLER L. WILLIAMS   |  | BALTIMORE, MD 21222   |  |
| No  |  | 212-36-7749  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | DUE TO, OR AS A CONSEQUENCE OF (c)  |  |
| 4100  |  | Cardiogenic Shock  |  | Anterior and Inferior Myocardial Infarct   |  | 24/45   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 7, 1982, to Aug 9, 1982, that (I) (we) lost                                |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 22f. REGISTRAR'S SIGNATURE   |  |   |  |
| Thomas A. Pearson M.D.  |  | Johns Hopkins Hospital   |  | John J. Connelley  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| Burial  |  | 8/13/82  |  | Gardens of Faith   |  | Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. DATE REC'D. BY REGISTRAR  |  | 24c. REGISTRAR'S SIGNATURE   |  |   |  |
| Duda-Ruck, Inc.   |  | AUG 12 1982  |  | John J. Connelley  |  |   |  |
| 7922 Wise Avenue, Dundalk, MD 21222   |  |  |  |  |  |   |  |





RECEIVED  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

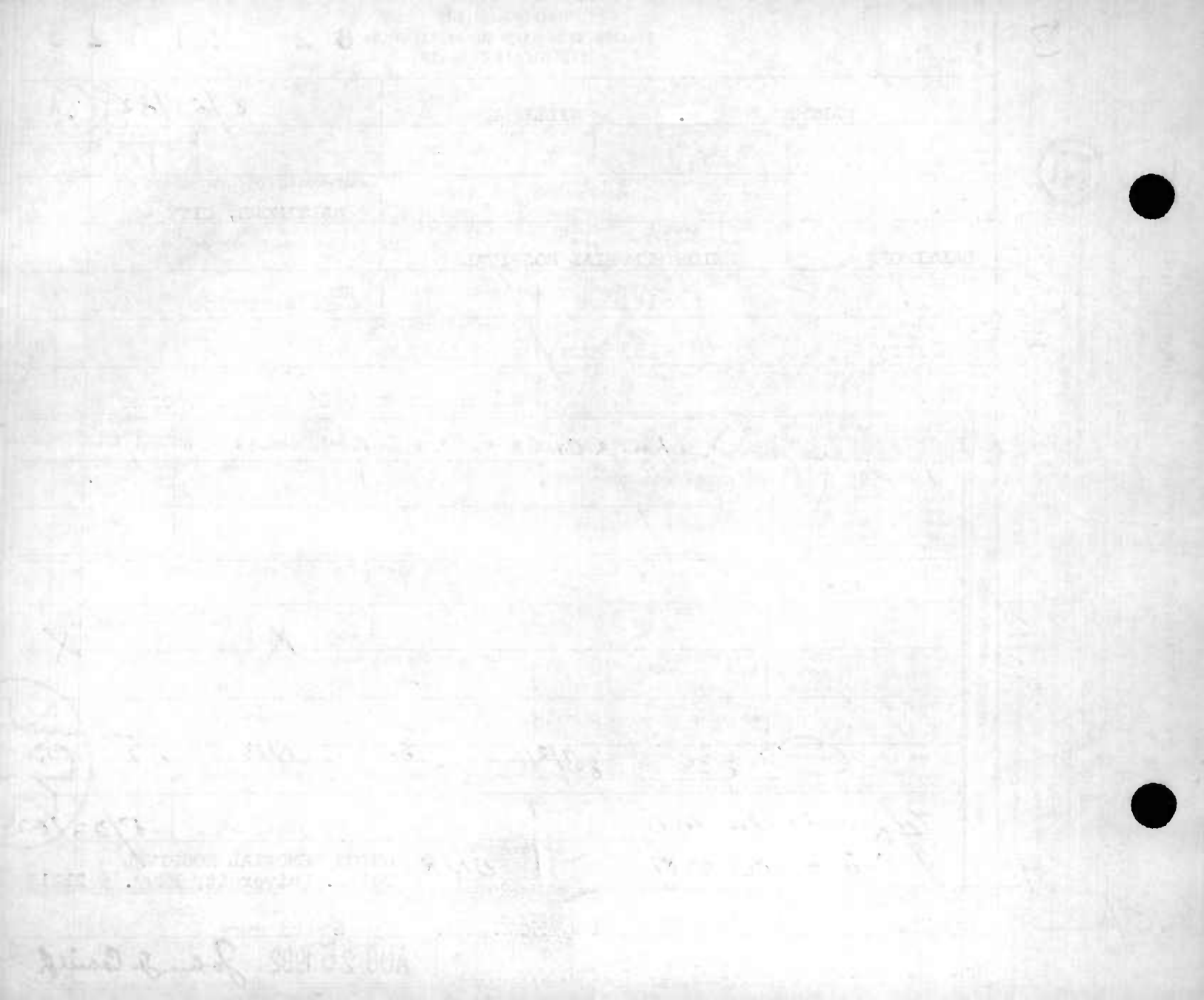
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/BI  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |   |  |  |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  |
| REG. NO.  |  |   |  |  |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARTHA Ruth WILLIAMS</b>   |  |   |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>8/23/82</b>                                   |  | 2b HOUR<br><b>6A</b> M  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 4 28</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>54</b>                                     |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a STATE<br><b>Maryland</b>  |  |   |  |  |  | 13b COUNTY  |  | 13c CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Jerry Williams</b>   |  |   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Omillion</b>                        |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b>   |  | 16b SOCIAL SECURITY NO.<br><b>N/A</b>   |  | 17 INFORMANT ADDRESS<br><b>Helen Brown 1368 Limit Avenue</b>   |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lung Ca.</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>None</b> |  |   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/23</b> 19 <b>82</b> , to <b>8/23</b> 19 <b>82</b> , that (I) (we) saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |   |  |
| 22b SIGNATURE<br><b>C. J. Huddleston M.D.</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br><b>8/23/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. J. HUDDLESTON</b>  |  |   |  | 22e ADDRESS<br><b>UNION MEMORIAL HOSPITAL<br/>201 E. University Pkwy. # 21218</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b DATE<br><b>8/27/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Pk.</b>   |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                      |  | 23e. DATE RECEIVED BY REGISTRAR<br><b>AUG 26 1982</b>   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H 1101 E. north Avenue</b>  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>AUG 26 1982</b>  |  |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |  |   |  | 25c. REGISTRAR'S SIGNATURE   |  |   |  |   |  |

2739 BP

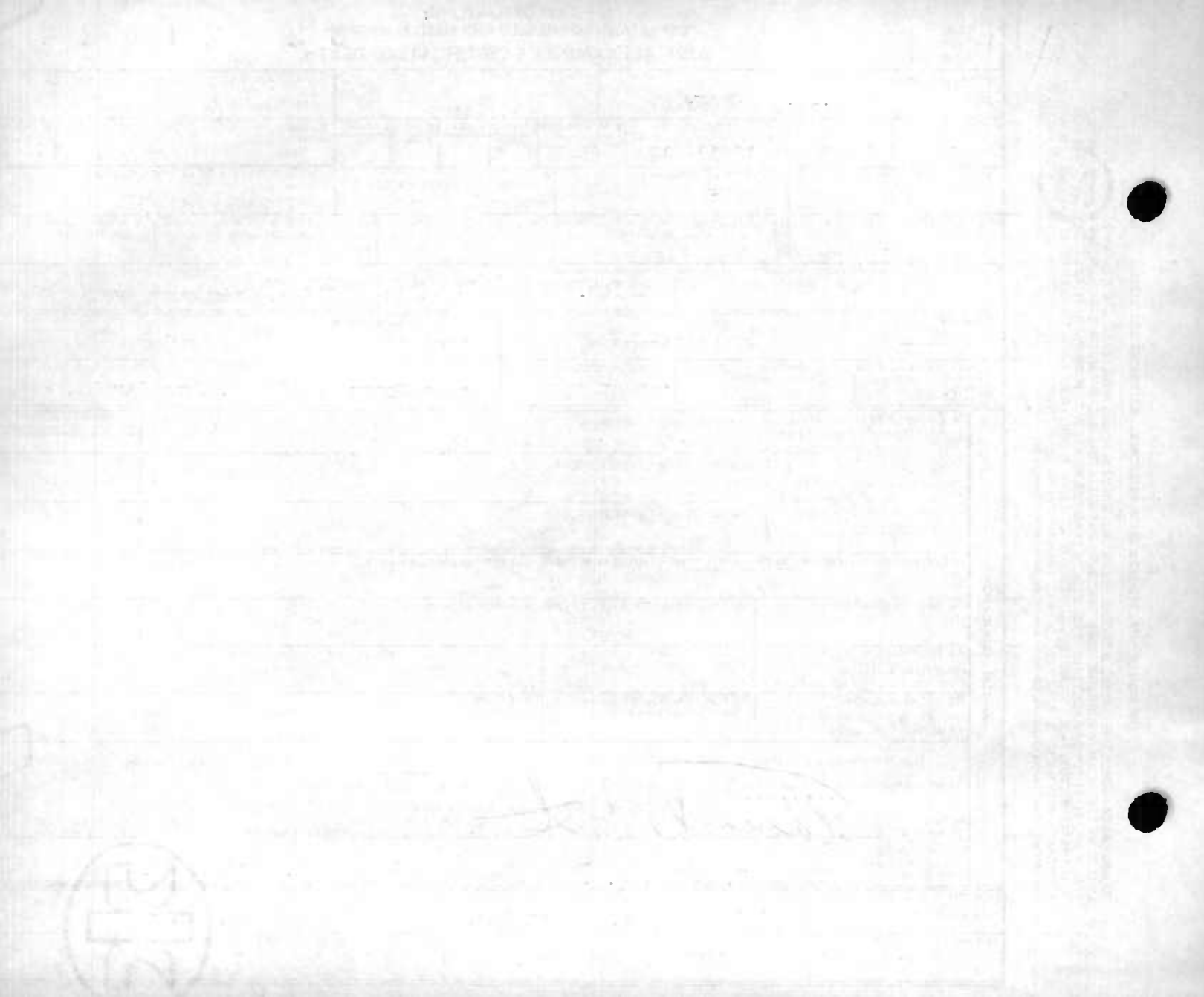


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

0604  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | REG. NO. 21024  |  |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Willie Henry Williams</b>  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>8</b> DAY <b>4</b> YEAR <b>1982</b> |  | 2b. HOUR <b>M</b>  |  |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>13</b> YEAR <b>12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>8</b> DAY <b>4</b> YEAR <b>1982</b> |  | 2d. HOUR <b>2:52P</b> <b>M</b>  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> <b>MD.</b>                                    |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1508 Fleet Street</b> |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO             |  | 13e. STREET ADDRESS <b>1916 E. Fairmount Ave.</b>                        |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>Williams</b> LAST  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Louise</b> MIDDLE <b>Taylor</b> LAST                                |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO. <b>217-07-9960</b>  |  | 17. INFORMANT <b>Paula Jones</b>   |  |  |  | ADDRESS <b>1208 W. Franklin St.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                            |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that I took charge of the deceased described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>   |  |   |  | TITLE (SPECIFY) <b>Deputy Chief</b>  |  |  |  | DATE SIGNED <b>8/5/82</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>  |  |   |  | ADDRESS <b>111 Penn St. Balto, Md.</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |   |  | 23b. DATE <b>8/9/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Md.</b> COUNTY STATE                    |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>AUG 06 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>                         |  |   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 1 0 2 5  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |  |  |                                      |
|---|---|---|--|---|--|--|--------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>C. VERNON WILLIAMSON</b>                 |   |   | 2a. DATE OF DEATH MONTH <b>8</b> DAY <b>5</b> YEAR <b>82</b> |   |  | 2b. HOUR <b>6:45 AM</b>                              |                                      |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b>                         | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>16</b> YEAR <b>10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>       |                                      |
| 7a. BIRTHPLACE<br>(COUNTRY) <b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |                                      |
| 11. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hosp</b>                |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>physician</b> |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME, GIVE STREET ADDRESS)<br>STATE <b>MD.</b> |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>Friendship Farm, Rt 32</b> |                                      |
| 14. FATHER'S NAME<br>FIRST <b>Edgar</b> MIDDLE <b>P.</b> LAST <b>Williamson</b> |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Florence</b> MIDDLE <b></b> LAST <b>Wickers</b>            |  |  |                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b> |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WW 11</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs Catherine Williamson 2915 Rte 32 21794</b>                      |  |  |                                      |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>0389</b> IMMEDIATE CAUSE (a) <b>respiratory failure</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>sepsis</b>   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>prolonged intubation</b>   |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  
**chronic obstructive pulmonary disease, congestive heart failure**

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION<br><b>7/7/82, 7/8/82</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>mitral valve regurg</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/10/82</b> , 19____, to <b>8/5/82</b> , 19____, that (I) (we) last<br>saw the deceased alive on <b>8/5/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |

|  |                       |  |                                   |
|--|-----------------------|--|-----------------------------------|
| 22b. SIGNATURE<br><b>Darla S. Holland, M.D.</b>                        | DEGREE<br><b>M.D.</b> | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>8/5/82</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DARLA S. HOLLAND, M.D.</b> |                       | 22e. ADDRESS<br><b>University of Maryland Hospital</b>   |                                   |

|  |                                 |  |  |
|--|---------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b> | 23b. DATE<br><b>Aug 9, 1982</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn</b> | 23d. LOCATION<br>CITY OR TOWN <b>Howard, Maryland</b> COUNTY STATE |
| 24. FUNERAL DIRECTOR<br><b>Harry H Witzke</b>              |                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG - 6 1982</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Cahill</b>                |





Items #18a-22a Film G572 10/7/82 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

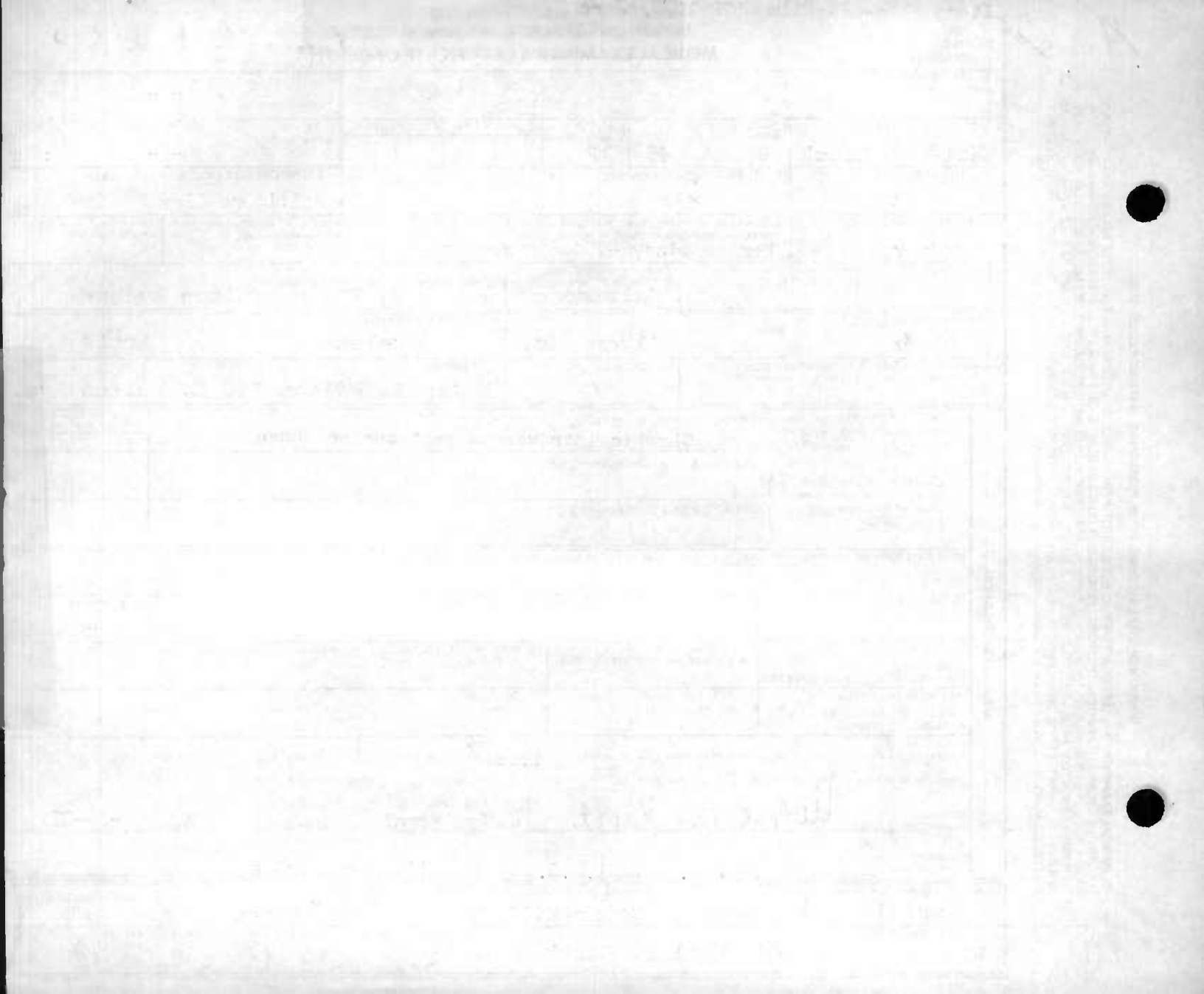
REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |  |                  |                 |   |  |   |  |   |      |  |  |   |  |  |                   |   |  |  |  |
|--|--|------------------|-----------------|---|--|---|--|---|------|--|--|---|--|--|-------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>ARNOLD |   |  | MIDDLE<br>WILSON                              |  |   | LAST |  |  | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>8-9-82 19                                       |  |  | 2b. HOUR<br>M     |   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 4 49  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>32 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS   |      | IF UNDER 24 HRS.<br>HOURS MIN.               |  | 2c. DATE PRONOUNCED DEAD<br>8-9-82 19   |  |  | 2d. HOUR<br>8:30P |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |                   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Penitentiary -954 Forest Street |  |   |  |   |      |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |  |                   | 12b. KIND OF BUSINESS OR INDUSTRY           |  |  |  |
| 13a. STATE<br>MD   |  |                  |                 | 13b. COUNTY   |  |   |  | 13c. CITY OR TOWN<br>Baltimore  |      |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                   | 13e. STREET ADDRESS<br>740 N. Fulton Avenue |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elmer Wilson Sr.   |  |                  |                 |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Artis  |      |  |  |   |  |  |                   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |  |   |  | 17. INFORMANT<br>ADDRESS<br>Helen A. Wilson 740 N. Fulton Ave.  |      |  |  |   |  |  |                   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic intravenous pentazocine abuse</u><br>9358<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                  |                 |   |  |   |  |   |      |  |  |   |  |  |                   |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |                 |   |  |   |  |   |      |  |  |   |  |  |                   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |      |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |                   |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |      |  |  |   |  |  |                   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |      |  |  |   |  |  |                   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                 |   |  |   |  |   |      |  |  |   |  |  |                   |   |  |  |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.  |  |                  |                 | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER  |      |  |  | DATE SIGNED<br>8-10-82  |  |  |                   |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                  |                 | ADDRESS<br>111 Penn Street  |  |   |  |   |      |  |  |   |  |  |                   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |                 | 23b. DATE<br>8/14/82  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.   |      |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD                                  |  |  |                   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  |                  |                 |   |  |   |  |   |      | 25a. DATE REC'D. BY REGISTRAR<br>AUG 11 1982 |  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Ganiel |  |                   |   |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |  |   |   |  |   |  | REG. NO. 21027 |  |
|---|--|-------------------------|--|--|--|--|---|---|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES WILSON</b>   |  |                         |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 8-10-82 |   |   | 2b. HOUR <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> 4:25A |   |  |                |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 5 11 27 |  | 6. AGE IN YEARS<br>(LAST BIRTHDAY) <input checked="" type="checkbox"/> 55 YRS.   |   | 7. IF UNDER 1 YR.<br>MONTHS <input checked="" type="checkbox"/> DAYS <input checked="" type="checkbox"/> HOURS <input checked="" type="checkbox"/> MIN. |  | 7c. DATE PRONOUNCED DEAD<br>8-10-82   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                    |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                            |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br><b>University Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY             |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>1803 N. Smallwood St.</b>   |  |   |  |                |  |
| 14. FATHER'S NAME<br>FIRST <b>Butty</b> MIDDLE <b>Wilson</b> LAST <b>Anderson</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Jannie</b> MIDDLE <b>Anderson</b> LAST <b>Anderson</b>  |   |   |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>216-20-8726</b>   |  | 17. INFORMANT ADDRESS<br><b>Fannie Hughes 1617 McKean Ave.</b>   |   |   |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stabwound of neck</b><br><b>9660</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |  |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                         |  |  |  |  |   |   |  |   |  |                |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3AM 8-10-82</b>  |  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)<br><b>subject stabbed</b>   |  |   |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)<br><b>street</b>   |  |  |   | 21f. LOCATION<br><b>1803 N. Smallwood Street Balto., Maryland</b>   |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                         |  |  |  |  |   |   |  |   |  |                |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |  |                         |  | M.D. <b>Deputy Chief</b>   |  |  |   | MEDICAL EXAMINER  |  |   | DATE SIGNED <b>8-10-82</b>                   |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>  |  |                         |  | ADDRESS <b>111 Penn Street</b>   |  |  |   |   |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>8/13/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>   |   |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD</b> STATE <b>MD</b>          |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 13 1982</b>  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                                      |   |  |                |  |

RECEIVED

2000

2000



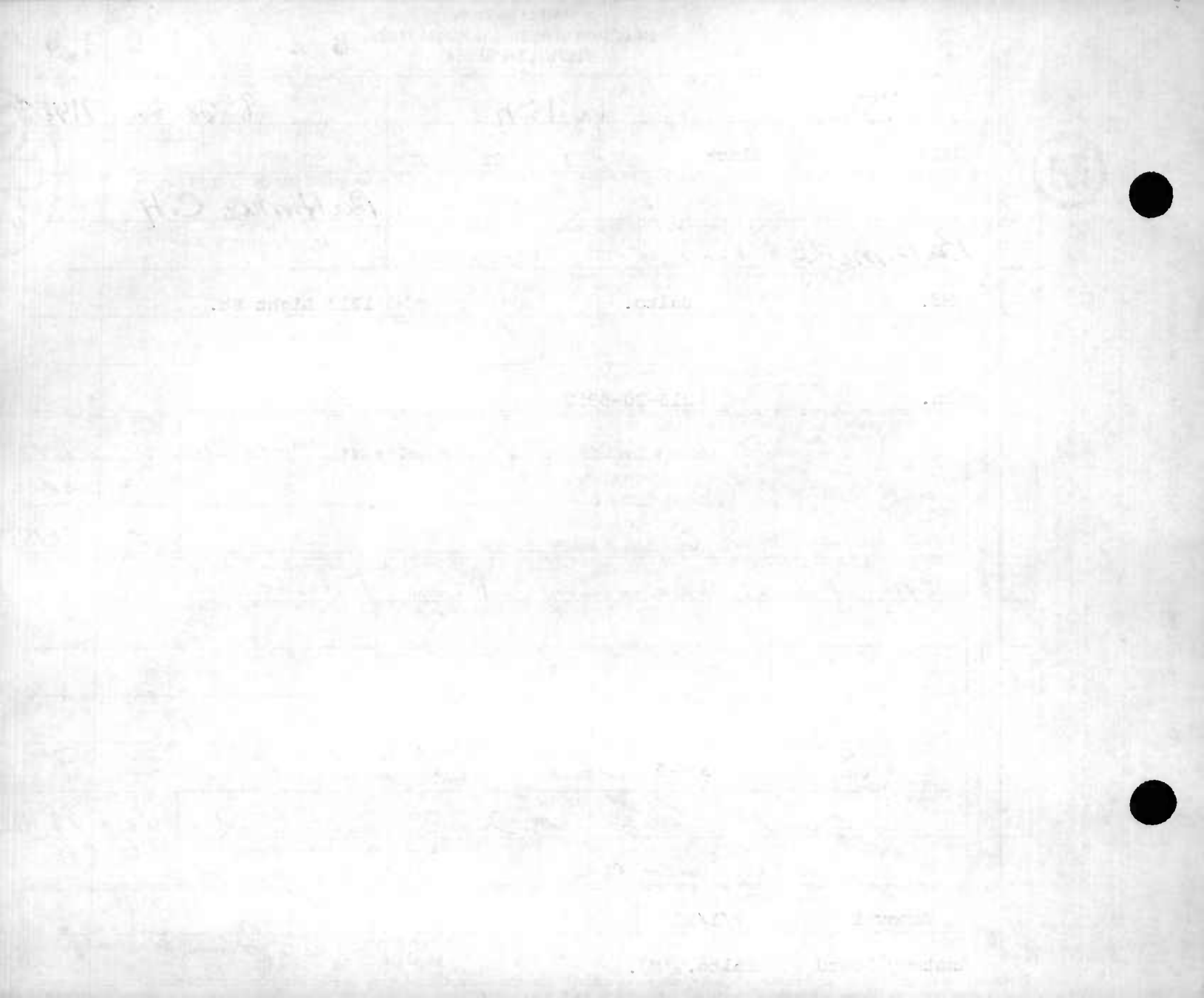
2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |  |   |                                    |   |  |  |                                   | 8 2 2 1 0 2 8<br>REG. NO.  |  |
|--|--|------------------------------|--|---|------------------------------------|---|--|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |                              |  |   | 2a. DATE OF DEATH                  |   | MONTH DAY YEAR                                       |  | 2b. HOUR                          |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Joe Wilson</u>   |  |                              |  |   | 8 28 82                            |   | 7:48 AM  |  |                                   |  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS  |  |
| Male   |  | Black                        |  | MONTH DAY YEAR<br>2 22 02   |                                    | 80 YRS  |  | MONTHS DAYS  |                                   | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |                                   |  |  |
|  |  |                              |  |   |                                    | Baltimore City MD.  |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Baltimore  |  |                              | PROVIDENT HOSPITAL   |   |                                    |   |  |  |                                   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY                  |  | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |                                   |  |  |
| Md.  |  |                              |  | Balto.  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 1213 Light St.   |                                   |  |  |
| 14. FATHER'S NAME  |  |                              |  |   | 15. MOTHER'S MAIDEN NAME           |   |  |  |                                   |  |  |
| FIRST MIDDLE LAST  |  |                              |  |   | FIRST MIDDLE LAST                  |   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                              |  |   | 16b. SOCIAL SECURITY NO.           |   | 17. INFORMANT ADDRESS                                |  |                                   |  |  |
| Unkn.  |  |                              |  |   | 213-20-5952                        |   |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>DISSEMINATED INTRAVASCULAR COAGULATION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEPTICEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>GANGRENE</u> |  |                              |  |   |                                    |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 DAYS<br>3 WEEKS<br>3 WEEKS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Below Knee Amputation, Renal Failure</u>  |  |                              |  |   |                                    |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |                                    | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |  |
|  |  |                              |  |   |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              | 21b. TIME OF INJURY  |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |                                   |  |  |
|  |  |                              | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |                                    |   |  |  |                                   |  |  |
| 21d. INJURY OCCURRED   |  |                              | 21e. PLACE OF INJURY   |   |                                    | 21f. LOCATION   |  |  |                                   |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                              | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |                                    | CITY OR TOWN COUNTY STATE   |  |  |                                   |  |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>Aug 5</u> , 19 <u>82</u> , to <u>Aug 28</u> , 19 <u>82</u> , that (I) <u>we</u> last saw the deceased alive on <u>Aug 28</u> , 19 <u>82</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (and I did not) view the body after death.    |  |                              |  |   |                                    |   |  |  |                                   |  |  |
| 22b. SIGNATURE   |  |                              |  |   |                                    | DEGREE  |  |  | 22c. DATE SIGNED                  |  |  |
| <u>Irving A. Cohen, M.D.</u>   |  |                              |  |   |                                    | M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | Aug 28, 1982                      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |  |   |                                    | 22e. ADDRESS  |  |  |                                   |  |  |
| IRVING A. COHEN, M.D.  |  |                              |  |   |                                    | 2600 LIBERTY AVE<br>BALTIMORE, MD   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION  |                                   |  |  |
| Removal  |  |                              | 9/1/82   |   |                                    |   |  | CITY OR TOWN COUNTY STATE                                      |                                   |  |  |
| 24. FUNERAL DIRECTOR   |  |                              |  |   |                                    |   | 25. DATE RECD. BY REGISTRAR OR REGISTRAR'S SIGNATURE |  |                                   |  |  |
| NAME ADDRESS<br>Anatomy Board Balto., Md.  |  |                              |  |   |                                    |   | SEP 8 1982 <u>John J. Smith</u>                      |  |                                   |  |  |



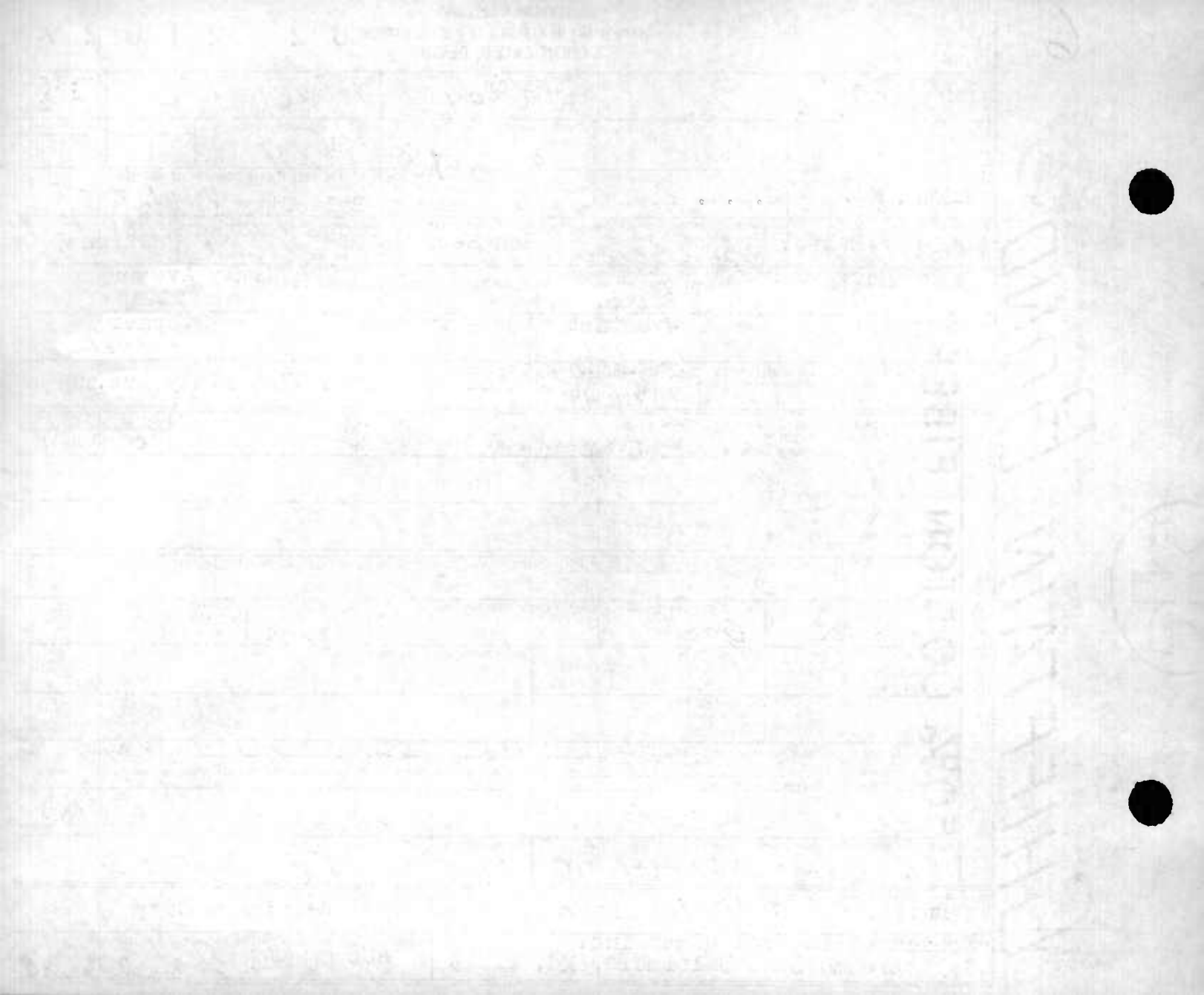
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and the medical certificate must be completed.

| 1. DECEASED NAME (TYPE OR PRINT)   |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH  |  | MONTH                    |  | DAY                                  |  | YEAR             |  | 2b. HOUR                                     |  | MIN.  |  |
|--|--|--|--|--|--|--|--|--------------------------|--|--------------------------------------|--|------------------|--|--|--|-------|--|
| Marie  |  | A.   |  | Wilson   |  | 8/8/82   |  | 8                        |  | 8                                    |  | 82               |  | 8:15   |  | A.M.  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE   |  | N YEARS (LAST BIRTHDAY)  |  | IF UNDER 1 YEAR                      |  | IF UNDER 24 HRS. |  |  |  |       |  |
| female F   |  | cauc W   |  | 4/7/98   |  | 84   |  | 84                       |  | YRS.                                 |  | MONTHS           |  | DAYS   |  | HOURS |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED   |  | NEVER MARRIED  |  | DIVORCED                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                  |  |  |  |       |  |
| Balto. Md.   |  | U.S.A.   |  | 4 Separated  |  | <input type="checkbox"/>                                       |  | <input type="checkbox"/> |  | Balto City                           |  | Balto City       |  | MD.  |  |       |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                          |  |                                      |  |                  |  |  |  |       |  |
| Balto.   |  | Bon Secours  |  | Retired  |  | National Can   |  |                          |  |                                      |  |                  |  |  |  |       |  |
| 13a. STATE   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS  |  |                          |  |                                      |  |                  |  |  |  |       |  |
| Md.  |  | Balto.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 3724 Elmley Avenue   |  |                          |  |                                      |  |                  |  |  |  |       |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  | 15. MOTHER'S NAME (FIRST MIDDLE LAST)  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)               |  | 16b. DATE OF DEATH   |  | 16c. INFORMANT           |  | ADDRESS                              |  |                  |  |  |  |       |  |
| Henry  |  | Mary   |  | No   |  | 215-12-1905  |  | Robert Wilson            |  | 3724 Elmley Avenue                   |  | 21213            |  |  |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF                                 |  | (b)                      |  | DUE TO, OR AS A CONSEQUENCE OF       |  | (c)              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |       |  |
| 4275   |  |  |  | Cardiopulmonary arrest   |  |  |  |                          |  |                                      |  |                  |  | 6-8 AM                                       |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |                          |  |                                      |  |                  |  |  |  |       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                          |  |                                      |  |                  |  |  |  |       |  |
| 8/5/82   |  | Good   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                          |  |                                      |  |                  |  |  |  |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |                          |  |                                      |  |                  |  |  |  |       |  |
|  |  | P.M. 19  |  |  |  |  |  |                          |  |                                      |  |                  |  |  |  |       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |                          |  |                                      |  |                  |  |  |  |       |  |
|  |  |  |  |  |  |  |  |                          |  |                                      |  |                  |  |  |  |       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/3, 19 82, to 8/8, 19 82, that (I) (we) lost   |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |                          |  |                                      |  |                  |  |  |  |       |  |
| saw the deceased alive on 8/8, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | W. C. MANARAY, MD  |  | MD   |  | 8/8/82   |  |                          |  |                                      |  |                  |  |  |  |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |                          |  |                                      |  |                  |  |  |  |       |  |
| W. C. MANARAY, MD  |  | 1905 York Rd   |  | 21093  |  |  |  |                          |  |                                      |  |                  |  |  |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY STATE                                       |  |                          |  |                                      |  |                  |  |  |  |       |  |
| Burial   |  | 8/11/82  |  | Parkwood Cemetery  |  | Baltimore City   |  |                          |  |                                      |  |                  |  |  |  |       |  |
| 24. FUNERAL HOME (NAME AND ADDRESS)  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                          |  |                                      |  |                  |  |  |  |       |  |
| Schmunk Funeral Homes Inc. 3331 Brehms Lane Baltimore, Md. 21213   |  | AUG 10 1982  |  | John J. Carver   |  |  |  |                          |  |                                      |  |                  |  |  |  |       |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| Item 7a G570 8/24/82 ph<br>FOR<br>1 - STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 2 2 1 0 3 0<br>REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Nathaniel</b> <b>Wilson</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 12 82</b>             |  | 2b. HOUR<br><b>8:45 PM</b>  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 12 25</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS   |   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b>                     |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Janitor</b>                                 | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>City</b>                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILSON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>VIRGINIA</b> <b>MICHAEL</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unknown</b> |   |
| 16b. SOCIAL SECURITY NO.<br><b>723-12-2782</b>   |  | 17. INFORMANT<br><b>Kenneth Wilson</b>  |  | ADDRESS<br><b>Fort Meade</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest; refractory bradyarrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia Cardiac Arrest &amp; Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Possible Pulmonary Embolus</b>                |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 min.</b><br><b>1 1/2 hrs.</b><br><b>1 1/2 hrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Severe Disorder. Alcoholism.</b>  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/24/82</b> , 19 <b>82</b> , to <b>8/12</b> , 19 <b>82</b> , that <b>(I) we</b> last saw the deceased alive on <b>8/12</b> , 19 <b>82</b> , and that in <b>(my) our</b> opinion death occurred on the date and hour and from the causes stated above; (If two doctors did not view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>John Bernstein</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>8/12/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Bernstein</b>   |  | 22e. ADDRESS<br><b>University Hospital, Baltimore</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8/17/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Md.</b>                                      |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b>   |  |   | 25. DATE RECEIVED BY REGISTRAR<br><b>AUG 16 1982</b>           |  |   |

U.S. S. B. 100-100000



On 10-10-10

Handwritten signature or text at the bottom left.

WOLF, DOROTHY

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 3 1

REG. NO.

|  |  |   |   |   |                            |  |
|--|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DOROTHY L. WOLF</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 19, 1982</b> |   | 2b. HOUR<br><b>05:00AM</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 25 1923</b>   |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS. MONTHS DAYS HOURS MIN.   |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>              |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   | 13. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |                            |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |   | 13c. INSIDE CITY LIMITS?<br><b>Yes</b> <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank M. Lomax</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marjorie E. Neal</b>  |   | 16. STREET ADDRESS<br><b>8006 Ridgely Oak Road</b>  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-18-5199</b>  |   | 17. INFORMANT<br><b>Louis G. Wolf, Jr. Baltimore, Md.</b>   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>4373 Card Vase Collapse</b><br>IMMEDIATE CAUSE (a) <b>SAN</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac aneurysm</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac aneurysm</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Anemia</b> |  |   |   |   |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>8/13 1982</b>   |                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                            |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   | 21h. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a. I certify that (this hospital) attended the deceased from <b>8/13</b> , 19 <b>82</b> , to <b>8/19</b> , 19 <b>82</b> , that (we) lost<br>saw the deceased alive on <b>8/19</b> , 19 <b>82</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |                            |  |
| 22b. SIGNATURE<br><b>R. J. Davis, M.D.</b>   |  | DEGREE  |   | 22c. DATE SIGNED<br><b>8/17/82</b>  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Davis, M.D.</b>  |  | 22e. ADDRESS<br><b>Baltimore, Md.</b>   |   | 22f. ADDRESS  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>8-21-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Hill</b>  |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Easton Talbot Md</b>  |  | 23e. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Easton Talbot Md</b>   |   | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Easton Talbot Md</b>   |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Newnam Funeral Home</b>   |  | ADDRESS<br><b>Easton, Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 23 1982</b>   |                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  | 25c. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |   | 25d. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |                            |  |

1 1 1 1 1 1 1 1 1 1

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

100:001 0801 1982

REPORT

MEMORANDUM

DATE: 10/10/82

100:001

100:001



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO. 21032   |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Gladys G. Wooden  |  |   |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>8 7 19 82 |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 6 17  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>65 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>8 12 19 82   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  | PM  |  | 2d. HOUR<br>4:30   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>827 N. Arlington Avenue |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>827 N. Arlington Avenue                                      |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Wooden   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lula Simms   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>219-16-7294   |  | 17. INFORMANT ADDRESS<br>Catherine Clark 5004 Elmer Avenue                                      |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>H. R. Guard</u> M.D.   |  |   |  |   |  | TITLE (SPECIFY)<br>Assistant  |  | DATE SIGNED<br>8/13/82  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |  |   |  |   |  | ADDRESS<br>111 Penn Street, Baltimore, MD   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>8/17/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Arburn Cemetery                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |   |  |   |  | ADDRESS<br>1101 E. North Avenue   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 17 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |

OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.

NOV 1917





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 2 1 0 3 3<br>REG. NO.   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>David Woodham</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>August 1, 1982</b>   |  | 2b. HOUR<br><b>4:42 AM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 6 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>717 Druid Park Lake Drive</b>   |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Ed Woodham</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Cora Lyde</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Vertell Shawn 1460 Bronx River Ave., NY</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629 Metastatic Oat Cell Carcinoma</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>June 14, 1982</b> , to <b>August 1, 1982</b> , that (X) (we) last saw the deceased alive on <b>August 1, 1982</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (we) did not examine the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Richard A. Lane</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>August 1, 1982</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard A. Lane, M.D.</b>   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>8-5-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Wm. C. Brown Comm. F/H 1206-08 W. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG - 2 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thom. J. [Signature]</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 3 4

REG. NO.

|   |           |  |  |  |  |  |  |
|---|-----------|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |           | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |           | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| FANNIE G. WOLPERT   |           |  |  | 8-9 82   |  | 10:45 PM   |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR   |  |
| FEMALE  | CAUCASIAN | MONTH DAY YEAR   |  | 86   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |           | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| RUSSIA  |           | USA  |  |  |  | BALT CITY MD   |  |
| 10. CITY OR TOWN OF DEATH   |           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALT.   |           | SINAI HOSP   |  | HOUSEWIFE  |  | AT HOME  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |           | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                       |  |
| MD  |           | XXXXXXX  |  | BALT   |  | YES XX NO <input type="checkbox"/>                             |  |
| 14. FATHER'S NAME   |           | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS  |  | 13f. APT. 1-J #21215   |  |
| FIRST MIDDLE LAST   |           | FIRST MIDDLE LAST  |  | 6503 PARK HTS. AVE.  |  |  |  |
| ELI   |           | BESSIE   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |           | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT  |  | 18. HARRY K. WOLPERT   |  |
| NO  |           | 214-74-0550  |  | 6503 PARK HTS. AVE., APT. 1-J  |  | #21215   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:   |           | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| 4100  |           | ACUTE MYOCARDIAL INFARCTION  |  | A.S. HD  |  | 2 HRS  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |           | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (c)  |  |
|   |           |  |  |  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |           |  |  |  |  |  |  |
| Diabetes mellitus   |           |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |           |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |           | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|   |           | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|   |           |  |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 19 73, to August 9 82, that (1) (we) last saw the deceased alive on August 7 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |           |  |  |  |  |  |  |
| 22b. SIGNATURE  |           | DEGREE   |  | 22c. DATE SIGNED   |  |  |  |
| Norman Horwitz  |           |  |  | 2-9-82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |           | 22e. ADDRESS   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  |
| NORRIS L. HORWITZ MD  |           | 64 PARK AVE BALTO 21201  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |           | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| BURIAL  |           | AUG. 10, 1982  |  | BNAI ISRAEL  |  | BALTIMORE MARYLAND   |  |
| 24. FUNERAL DIRECTOR  |           | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| SOL LEVINSON & BROS., INC.  |           | AUG 13 1982  |  | John J. Carver   |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD  |           | 21215  |  |  |  |  |  |

1. The purpose of this report is to provide a summary of the activities of the Office of the Chief of Staff during the period from 1 January to 31 December 1964.

2. The Office of the Chief of Staff has been actively engaged in the planning and execution of the operations of the Department of the Army during the year 1964.

3. The Office of the Chief of Staff has been actively engaged in the planning and execution of the operations of the Department of the Army during the year 1964.

4. The Office of the Chief of Staff has been actively engaged in the planning and execution of the operations of the Department of the Army during the year 1964.

5. The Office of the Chief of Staff has been actively engaged in the planning and execution of the operations of the Department of the Army during the year 1964.

6. The Office of the Chief of Staff has been actively engaged in the planning and execution of the operations of the Department of the Army during the year 1964.

7. The Office of the Chief of Staff has been actively engaged in the planning and execution of the operations of the Department of the Army during the year 1964.

8. The Office of the Chief of Staff has been actively engaged in the planning and execution of the operations of the Department of the Army during the year 1964.

9. The Office of the Chief of Staff has been actively engaged in the planning and execution of the operations of the Department of the Army during the year 1964.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 8 2 2 1 0 3 5<br>REG. NO.                    |              |  |  |   |  |
|---|--|--|--|--|--|---|--|--|--|--|--------------|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |   |  |  |  |  |              |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>EDWARD JEROME <del>WORMLEY</del> WORLEY   |  |  |  |  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 8 82   |              |  |  | 2b. HOUR<br>9:30 P.M.   |  |
| 3 SEX<br>MALE   |  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6-25-1921                                   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS               |              | IF UNDER 72 HRS<br>HOURS MIN.                          |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |              |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC BALTIMORE, MARYLAND 21218 |  |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver  |  |              | 12b. KIND OF BUSINESS OR INDUSTRY<br>Truck Driving Co. |  |   |  |
| 13a. STATE<br>Md.   |  |  |  |  |  |   |  |  |  | 13b. COUNTY<br>Baltimore                     |              | 13c. CITY OR TOWN<br>Baltimore                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Lawrence Worley  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Amelia Marshall  |  |  | 13e. STREET ADDRESS<br>2037 Harman Ave. 21230   |  |  |  |  |              |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  |  | 16b. SOCIAL SECURITY NO.<br>217 09 4954  |  |  | 17. INFORMANT ADDRESS<br>Lillian Worley - 2037 Harman Ave. 21230  |  |  |  |  |              |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1850 IMMEDIATE CAUSE (a) <u>Respiratory Arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC Prostate Ca.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |              |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |  |   |  |  |  |  |              |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |              |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) |   |  |  |  |  |              |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |              |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/4</u> , 19 <u>82</u> , to <u>8/8</u> , 19 <u>82</u> , that (we) last saw the deceased alive on <u>8/8</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |              |  |  |   |  |
| 22b. SIGNATURE<br>J. Howell M.D.  |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  | 22c. DATE SIGNED<br>8/9/82   |  |              |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Howell M.D.   |  |  | 22e. ADDRESS<br>V.A. Med. Center - Loch Raven  |  |  |   |  |  |  |  |              |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Buried   |  |  | 23b. DATE<br>8-12-1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Park Cem.                      |   |  | 23d. LOCATION<br>Cath. Md.                 |  |  | COUNTY STATE |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John J. Brown, Sr. 901 Madison St.  |  |  | ADDRESS<br>Baltimore Md. 21223   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>'AUG 11 1982   |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |              |  |  |   |  |

W. J. ...

13-1-25

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 12th inst. regarding the matter of the ...

Very respectfully,  
[Signature]

Very truly yours,  
[Signature]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMHM - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |   |   |  |  |  |   |  | REG. NO. 21036                               |  |
|---|-------------------------|--|---|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANDREW J. WORTH</b>  |                         |  |   |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>8-2-82</b> |  | 2b. HOUR <b>1:54P</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>5</b> YEAR <b>1921</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b>5</b> DAYS <b>19</b>  | IF UNDER 24 HRS.<br>HOURS <b>1</b> MIN <b>54</b> | 2c. DATE PRONOUNCED DEAD <b>8-2-82</b>   |  | 2d. HOUR <b>1:54P</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Asst. Auditor</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Banking</b>                                 |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore City</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>32 D Leatherwood Place</b>                                |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Andrew</b> MIDDLE <b>J.</b> LAST <b>Worth, Sr.</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Caroline</b> MIDDLE <b>Murphy</b> LAST <b>Murphy</b>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         | (IF YES, GIVE WAR OR DATES)<br><b>WWII</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>288-14-3318</b>  |  | 17. INFORMANT<br><b>Mrs. Ruth Worth</b>  |  | ADDRESS <b>10560 Fairlawn Dr. Parma, Ohio 44130</b>                                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |   |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |   |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                         |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Margaret A. Korell</b>  |                         |  |   | TITLE (SPECIFY)<br><b>M.D. Assistant</b>  |  |  |  | DATE SIGNED <b>8-3-82</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |                         |  |   | ADDRESS <b>111 Penn Street</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>8-6-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Elmhurst Cemetery</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Avon</b> COUNTY <b>Lorain</b> STATE <b>Ohio</b>    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Marzullo Funeral Service</b> ADDRESS <b>Reisterstown, Maryland</b>  |                         |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG - 6 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                 |  |  |  |

BP



1941

X

Wm. A. Addison

32 S. Lancaster Ave.

Bellevue City

Bellevue City

Caroline

North

North

10:30  
10:30  
10:30

100-1-1211

100-1-1211

100-1-1211

RECEIVED

100-1-1211

100-1-1211

100-1-1211

100-1-1211

100-1-1211

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 3 7

REG. NO.

1 - FOR  
STATE  
REGISTRAR

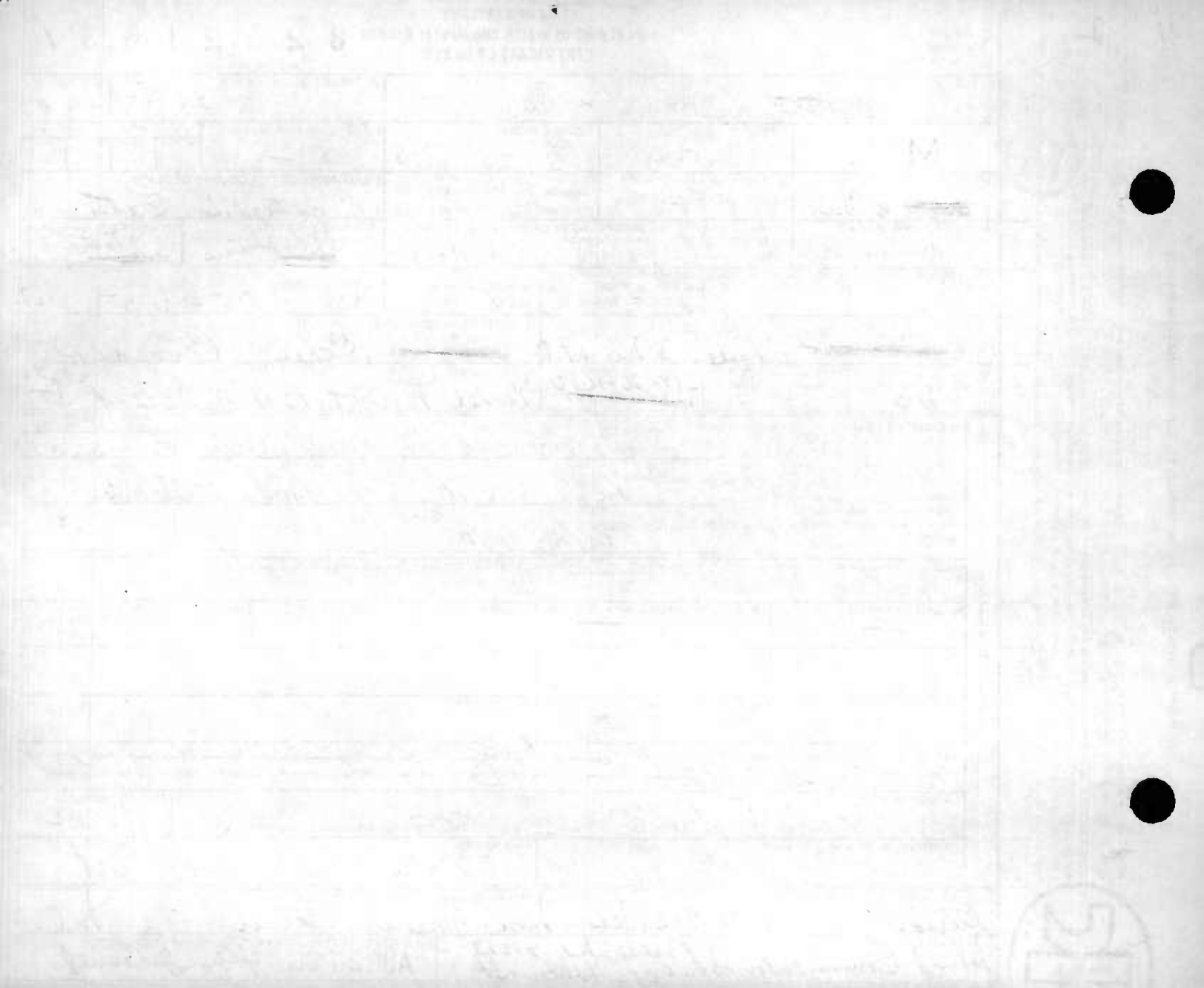
|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><del>ROBERT</del> CHARLES H. WRIGHT              |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>8 24 82  |  | 2b. HOUR<br>300 P.M.   |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 30 1930   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hosp. |   | 12. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Mechanic                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Motor Co.                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>MD. | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1228 W. OSTEND ST. 21230                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><del>UN</del> Charles J. Wright Jr.                                |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><del>UNKNOWN</del> Ethel Breeden   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                   |   | 16b. SOCIAL SECURITY NO.<br>418-26-1680   |   | 17. INFORMANT<br>ADDRESS<br>Rachel Wright - 1228 W. Ostend St. 21230 |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br><u>3030</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypotension renal failure, hepatic coma, septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>HEPATORENAL Syndrome, peritonitis</u><br><u>ALCOHOLISM</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

|  |  |   |   |
|--|--|---|---|
| 19a. DATE OF OPERATION<br>—  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>8/15</u> 19 <u>82</u> to <u>8/24</u> 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>8/24</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |   |
| 22b. SIGNATURE<br>John Vitarello MD  | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>8/24/82   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN VITARELLO MD   |  | 22e. ADDRESS<br>22 GREEN ST, BALT MD  |   |

|   |                        |   |  |
|---|------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br>Burial                | 23b. DATE<br>8-28-1982 | 23c. NAME OF CEMETERY OR CREMATORY<br>Belair Mem. Gardens | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Ind. |
| 24. FUNERAL DIRECTOR<br>NAME<br>John E. Brown & Son Inc. 901 Hallway St |                        | 25a. DATE REC'D. BY REGISTRAR<br>AUG 27 1982              |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Conner                            |                        |   |  |



item 8/25/82 8/31/82 ph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MATTIE WRIGHT</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 2 82</b> |   |  | 2b. HOUR<br><b>9:45 PM</b>   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>B</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 5 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Luthern Hosp of Md</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br><b>Poplar Manor NH</b> |  |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3313 Poplar St</b>                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert Tucker</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Eliza Tucker</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>?</b> IF YES, GIVE WAR OR DATES  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>250-50-8963</b>  |  | 17. INFORMANT ADDRESS<br><b>Lois Fuller 3319 Lynne Haven Drive</b> |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br><b>5990</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Septic shock</b><br>(c) <b>Urinary tract sepsis</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>8/2 19 82</b>    |  | 21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/2 19 82</b> to <b>8/2 19 82</b> , that (I) (we) lost above, (I) (we) did (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>John A. Covington</b> DEGREE <b>MD</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>8/2/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John A. Covington</b>  |  |   |  | 22e. ADDRESS   |  |   |  |

|  |  |                            |  |   |  |  |  |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>8/8/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Liberty C. Cem</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Laurens Co. S.C.</b> |  |
|--|--|----------------------------|--|---|--|--|--|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 24. FUNERAL DIRECTOR NAME<br><b>Chas. A. Rice FSPA 1300 Eutaw Pl.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 17 1982</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b> |  |
|---|--|---|--|---|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text, possibly a date or reference number, appearing as '10-10-10' or similar.

Handwritten text at the bottom of the page, including what appears to be a signature and some illegible notes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND  |  |   |  |   |  |  |                                  |   |  |  |
|--|--|---|--|---|--|--|----------------------------------|---|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |                                  |   |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |                                  |   |  |  |
| REG. NO. 8 2 2 1 0 3 9   |  |   |  |   |  |  |                                  |   |  |  |
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |                                  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>TERESA WRIGHT  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 30 82                |  | 2b. HOUR<br>3 <sup>00</sup> A.M. |   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 19 58   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>23 YRS.                             |                                  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.             |                                  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)          |                                  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ozell   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annie Weaver |  |                                  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>216-78-6436   |  | 17. INFORMANT ADDRESS<br>Annie Wright 1900 E. Baltimore St.   |  |  |                                  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |                                  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |   |  |   |  |  |                                  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |                                  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                                  |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 8/29, 19 82, to 8/30, 19 82, that (1) (we) last saw the deceased alive on 8/30, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |                                  |   |  |  |
| 22b. SIGNATURE<br>Robert A. Weisgrau MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |                                  | 22c. DATE SIGNED<br>8/10/82   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT A. WEISGRAU MD   |  |   |  | 22e. ADDRESS<br>BALTIMORE CITY HOSPITAL   |  |  |                                  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>9/4/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.               |                                  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 E. North avenue   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 1 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Joan L. Canine                           |                                  |   |  |  |

4106



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 4 0

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HARRY WUSEK</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8/19/82</b>  |  | 2b. HOUR<br><b>2<sup>45</sup> A M</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUC.</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 - 23 - 12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70 yrs</b> YRS MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO MD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CITY HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RET.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WALTER WUSEK</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LUCE MAZUREK</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-10-1134</b>   |  | 17. INFORMANT ADDRESS<br><b>MARYANNA WUSEK 600 S. ROSE ST.</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory + Cardiac Arrest</b><br>1519<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Gastric Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>NO</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/15</b> , 19 <b>82</b> , to <b>8/19</b> , 19 <b>82</b> , that (I) (we) lost <b>8/19</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Rudolph E. Emerick</b>  |  | DEGREE<br><b>—</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>8/19/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rudolph E. Emerick</b>   |  | 22e. ADDRESS<br><b>—</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>8/23/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>KACZOROWSKI FUNERAL HOME</b>   |  | ADDRESS<br><b>3525 Fleet St</b>  |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>AUG 24 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information other than death information.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   |  |   |   |   |  |  |
|--|--|--|---|---|--|---|---|---|--|--|
| 1- FOR STATE REGISTRAR   |  | 8 2 2 1 0 4 1<br>CERTIFICATE OF DEATH<br>REG. NO.  |   |   |  |   |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Elizabeth H. Yearley</b>   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>8 / 1 / 82</b>                          |   |   | 2b. HOUR<br><b>6<sup>10</sup> P<sup>M</sup></b>               |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 1, 1907</b>  |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>74</b> YRS.  |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>J. L. Deaton Medical Center</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager Trans.</b>              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Govt. Wash. State</b> |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |   |   | 13b. CITY OR TOWN<br><b>Baltimore</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13d. STREET ADDRESS<br><b>27 Somerset Rd.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Joseph Howard</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth Christian</b>  |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>219-28-5412</b>  |  | 17. INFORMANT ADDRESS<br><b>Cincinnati, Ohio 45244</b><br><b>Elizabeth Groszer-8187 Capitol Dr.</b> |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) Metastatic Pulmonary Carcinoma</b>  |  |  |   |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Brain metastases</b>  |  |  |   |   |  |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |   |  |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ( )   |  |  |   |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION:  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |   |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>July 23</b> 19 <b>82</b> to <b>Aug 1</b> 19 <b>82</b> that (2) ( ) last saw the deceased alive on <b>Aug 1</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. |  |  |   |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Julian W. Reed</b>  |  |  |   | DEGREE<br><b>MD</b>   |  |   |   | 22c. DATE SIGNED<br><b>8/2/82</b>                             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIAN W. REED</b>   |  |  |   | 22e. ADDRESS<br><b>1115 S. CHAS. ST. BALTO MD 21238</b>   |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |  | 23b. DATE<br><b>Aug. 2, 1982</b>                                    |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b>                |   | 23d. LOCATION CITY OR TOWN COUNTY<br><b>Westview Balto. MD.</b>                                 |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leroy M. &amp; Russell C. Witzke Funeral Home P.A.</b><br><b>1630 Edmondson Ave., Catonsville, MD. 21228</b>  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 06 1982</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |   |  |  |

DATE: 10/10/1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |                      |  |  |  |  |  |  | 8 2 2 1 0 4 2  |          |  |
|--|--|---|----------------------|--|--|--|--|--|--|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   | CERTIFICATE OF DEATH |  |  |  |  |  |  |  | REG. NO. |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |                      |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR   |          |  |
| FIRST MARY MIDDLE CATHERINE LAST YINGER  |  |   |                      |  |  | MONTH 8 DAY 20 YEAR 82   |  |  |  | 9:50A  |          |  |
| 3. SEX   |  | 4. RACE   |                      | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |          |  |
| FEMALE   |  | WHITE   |                      | MONTH 9 DAY 25 YEAR 20   |  | 61 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.   |          |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |          |  |
| Maryland   |  | U.S.A.  |                      |  |  | Baltimore City MD.   |  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                      |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |          |  |
| Baltimore  |  | St. Agnes Hospital  |                      |  |  | Secretary  |  | Venetian Blinds  |  |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |                      |  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |  |          |  |
| 13a. STATE   |  | 13b. COUNTY   |                      | 13c. CITY OR TOWN  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 1631 Parkman Avenue  |  |  |          |  |
| Maryland   |  |   |                      | Baltimore  |  |  |  |  |  |  |          |  |
| 14. FATHER'S NAME  |  |   |                      |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |          |  |
| FIRST MIDDLE LAST Clarence = Crum  |  |   |                      |  |  | FIRST MIDDLE LAST Rhiba = Kelley   |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT ADDRESS  |  |  |  |  |          |  |
| no   |  |   |                      | 214-16-1927  |  | Lawrence G. Yinger # 107 Maple Ave. Pasadena, Md.                              |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic Small Cell Carcinoma of Lung.</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)       |  |   |                      |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Hypocalcemia, Fever</u>  |  |   |                      |  |  |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |  |
|  |  |   |                      |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 18</u> , 19 <u>82</u> , to <u>August 20</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Aug. 19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |                      |  |  |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |   |                      |  |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>8-20-82                                    |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |                      |  |  | 22e. ADDRESS   |  |  |  |  |          |  |
|  |  |   |                      |  |  |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |                      | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |          |  |
| Burial   |  |   |                      | 8/23/1982  |  | Baltimore Nat'l.   |  | Baltimore City, Maryland   |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |                      |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |          |  |
| Raymond C. Fink  |  |   |                      |  |  | Glen Burnie, Md.   |  | AUG 25 1982  |  | <u>[Signature]</u>   |          |  |

MEDICAL CERTIFICATION

9 9

35 40 35 300

1

2582 BP

45384-101103-0000



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

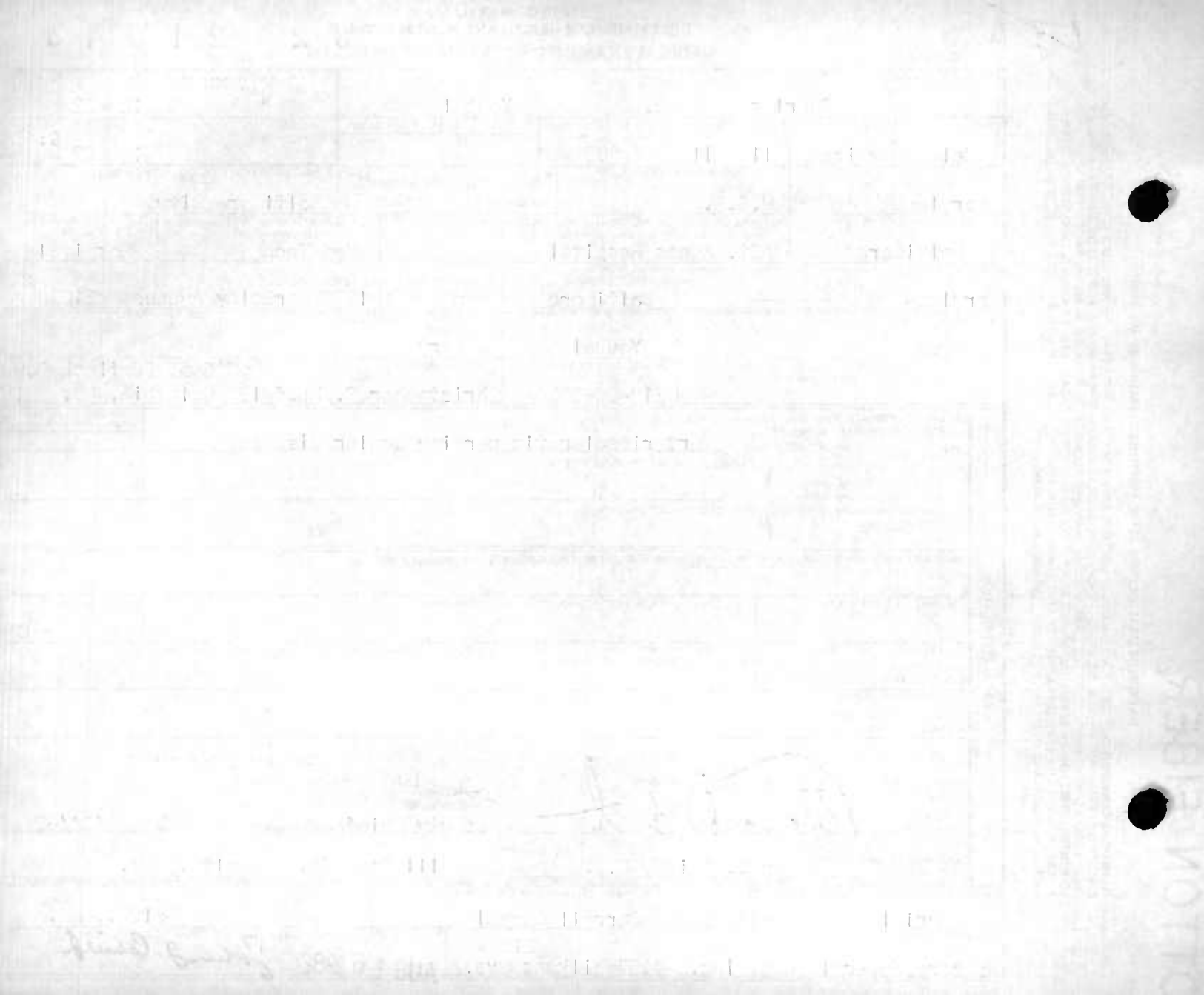
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

21043

|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|-------------------------|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | 2. DATE KNOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 3. MONTH DAY YEAR  |  |  |  |  |  |  |  |  |  | 4. HOUR   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | Charles R. Youkel  |  |  |  |  |  |  |  |  |  | 8  |  |  |  |  |  |  |  |  |  | 12  |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                       |  |  |  |  |  |  |  |  |  | M                       |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS)   |  |  |  |  |  |  |  |  |  | 7. IF UNDER 1 YR.        |  |  |  |  |  |  |  |  |  | 8. IF UNDER 24 HRS.      |  |  |  |  |  |  |  |  |  | 9. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |  |  | 10. MONTH DAY YEAR |  |  |  |  |  |  |  |  |  | 11. HOUR |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Male  |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | 11 11 06   |  |  |  |  |  |  |  |  |  | 75 YRS.   |  |  |  |  |  |  |  |  |  | MONTHS DAYS HOURS MIN    |  |  |  |  |  |  |  |  |  | 8                        |  |  |  |  |  |  |  |  |  | 12                      |  |  |  |  |  |  |  |  |  | 19                 |  |  |  |  |  |  |  |  |  | 82       |  |  |  |  |  |  |  |  |  | M  |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  |  |  |  |  |  |  | 13. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 14. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 15. BALTIMORE CITY OR COUNTY OF DEATH                               |  |  |  |  |  |  |  |  |  | 16. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |  |  | 17. MONTH DAY YEAR       |  |  |  |  |  |  |  |  |  | 18. HOUR                |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                     |  |  |  |  |  |  |  |  |  | Baltimore City,   |  |  |  |  |  |  |  |  |  | 8                        |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                      |  |  |  |  |  |  |  |  |  | 82                 |  |  |  |  |  |  |  |  |  | M        |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 20. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |  |  |  |  |  |  |  |  | 21. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                           |  |  |  |  |  |  |  |  |  | 22. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |  |  |  |  |  |  | 23. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |  |  | 24. MONTH DAY YEAR       |  |  |  |  |  |  |  |  |  | 25. HOUR                |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Baltimore   |  |  |  |  |  |  |  |  |  | St. Agnes Hospital   |  |  |  |  |  |  |  |  |  | Med Tech   |  |  |  |  |  |  |  |  |  | Hospital  |  |  |  |  |  |  |  |  |  | 8                        |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                      |  |  |  |  |  |  |  |  |  | 82                 |  |  |  |  |  |  |  |  |  | M        |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 26. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                      |  |  |  |  |  |  |  |  |  | 27. STATE  |  |  |  |  |  |  |  |  |  | 28. CITY OR TOWN   |  |  |  |  |  |  |  |  |  | 29. INSIDE CITY LIMITS?   |  |  |  |  |  |  |  |  |  | 30. STREET ADDRESS       |  |  |  |  |  |  |  |  |  | 31. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |  |  | 32. MONTH DAY YEAR      |  |  |  |  |  |  |  |  |  | 33. HOUR           |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | -----  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 1930 Parksley Avenue     |  |  |  |  |  |  |  |  |  | 8                        |  |  |  |  |  |  |  |  |  | 12                      |  |  |  |  |  |  |  |  |  | 19                 |  |  |  |  |  |  |  |  |  | 82       |  |  |  |  |  |  |  |  |  | M  |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 34. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 35. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  | 36. DATE PRONOUNCED DEAD   |  |  |  |  |  |  |  |  |  | 37. MONTH DAY YEAR  |  |  |  |  |  |  |  |  |  | 38. HOUR                 |  |  |  |  |  |  |  |  |  | 39. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |  |  | 40. MONTH DAY YEAR      |  |  |  |  |  |  |  |  |  | 41. HOUR           |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Anton   |  |  |  |  |  |  |  |  |  | Mary   |  |  |  |  |  |  |  |  |  | 8  |  |  |  |  |  |  |  |  |  | 12  |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                       |  |  |  |  |  |  |  |  |  | M                       |  |  |  |  |  |  |  |  |  | 8                  |  |  |  |  |  |  |  |  |  | 12       |  |  |  |  |  |  |  |  |  | 19 |  |  |  |  |  |  |  |  |  | 82 |  |  |  |  |  |  |  |  |  | M |  |  |  |  |  |  |  |  |  |
| 42. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |  |  |  |  |  |  |  |  | 43. SOCIAL SECURITY NO.  |  |  |  |  |  |  |  |  |  | 44. INFORMANT  |  |  |  |  |  |  |  |  |  | 45. ADDRESS   |  |  |  |  |  |  |  |  |  | 46. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |  |  | 47. MONTH DAY YEAR       |  |  |  |  |  |  |  |  |  | 48. HOUR                |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| NO  |  |  |  |  |  |  |  |  |  | 212-20-8026  |  |  |  |  |  |  |  |  |  | Christopher C. Hupfeld   |  |  |  |  |  |  |  |  |  | 6953 Sunfleck Row   |  |  |  |  |  |  |  |  |  | 8                        |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                      |  |  |  |  |  |  |  |  |  | 82                 |  |  |  |  |  |  |  |  |  | M        |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 49. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | 50. IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  | 51. DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | 52. DATE PRONOUNCED DEAD  |  |  |  |  |  |  |  |  |  | 53. MONTH DAY YEAR       |  |  |  |  |  |  |  |  |  | 54. HOUR                 |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 4292  |  |  |  |  |  |  |  |  |  | Arteriosclerotic cardiovascular disease  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | 8   |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                      |  |  |  |  |  |  |  |  |  | M                  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                       |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | 8   |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                      |  |  |  |  |  |  |  |  |  | M                  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 8   |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                      |  |  |  |  |  |  |  |  |  | M                  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 8   |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                      |  |  |  |  |  |  |  |  |  | M                  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 55. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 56. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  |  |  | 57. AUTOPSY?   |  |  |  |  |  |  |  |  |  | 58. DATE PRONOUNCED DEAD  |  |  |  |  |  |  |  |  |  | 59. MONTH DAY YEAR       |  |  |  |  |  |  |  |  |  | 60. HOUR                 |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |  |  |  |  |  |  |  |  | 8   |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                      |  |  |  |  |  |  |  |  |  | M                  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 61. EXTERNAL CAUSE WAS  |  |  |  |  |  |  |  |  |  | 62. TIME OF INJURY   |  |  |  |  |  |  |  |  |  | 63. HOW INJURY OCCURRED  |  |  |  |  |  |  |  |  |  | 64. DATE PRONOUNCED DEAD  |  |  |  |  |  |  |  |  |  | 65. MONTH DAY YEAR       |  |  |  |  |  |  |  |  |  | 66. HOUR                 |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  |  |  |  |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2                                     |  |  |  |  |  |  |  |  |  | 8   |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                      |  |  |  |  |  |  |  |  |  | M                  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 67. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 68. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  |  |  |  |  |  |  | 69. LOCATION   |  |  |  |  |  |  |  |  |  | 70. DATE PRONOUNCED DEAD  |  |  |  |  |  |  |  |  |  | 71. MONTH DAY YEAR       |  |  |  |  |  |  |  |  |  | 72. HOUR                 |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | STREET, FACTORY, FARM, ETC.)   |  |  |  |  |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  | 8   |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                      |  |  |  |  |  |  |  |  |  | M                  |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 73. I certify that I took charge of the remains described above, held on  |  |  |  |  |  |  |  |  |  | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion   |  |  |  |  |  |  |  |  |  | 74. DATE PRONOUNCED DEAD   |  |  |  |  |  |  |  |  |  | 75. MONTH DAY YEAR  |  |  |  |  |  |  |  |  |  | 76. HOUR                 |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| death resulted from:  |  |  |  |  |  |  |  |  |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 8  |  |  |  |  |  |  |  |  |  | 12  |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                       |  |  |  |  |  |  |  |  |  | M                       |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 77. ACTUAL SIGNATURE  |  |  |  |  |  |  |  |  |  | 78. TITLE (SPECIFY)  |  |  |  |  |  |  |  |  |  | 79. DATE PRONOUNCED DEAD   |  |  |  |  |  |  |  |  |  | 80. MONTH DAY YEAR  |  |  |  |  |  |  |  |  |  | 81. HOUR                 |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Thomas D. Smith, M.D.   |  |  |  |  |  |  |  |  |  | M.D. Deputy Chief  |  |  |  |  |  |  |  |  |  | 8  |  |  |  |  |  |  |  |  |  | 12  |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                       |  |  |  |  |  |  |  |  |  | M                       |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 82. EXAMINER'S NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | 83. ADDRESS  |  |  |  |  |  |  |  |  |  | 84. DATE PRONOUNCED DEAD   |  |  |  |  |  |  |  |  |  | 85. MONTH DAY YEAR  |  |  |  |  |  |  |  |  |  | 86. HOUR                 |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |                         |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Thomas D. Smith, M.D.   |  |  |  |  |  |  |  |  |  | 111 Penn St. Balto., MD.   |  |  |  |  |  |  |  |  |  | 8  |  |  |  |  |  |  |  |  |  | 12  |  |  |  |  |  |  |  |  |  | 19                       |  |  |  |  |  |  |  |  |  | 82                       |  |  |  |  |  |  |  |  |  | M                       |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 87. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |  |  |  |  | 88. DATE   |  |  |  |  |  |  |  |  |  | 89. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  |  |  |  |  | 90. LOCATION  |  |  |  |  |  |  |  |  |  | 91. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |  |  | 92. MONTH DAY YEAR       |  |  |  |  |  |  |  |  |  | 93. HOUR                |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | 8-14-82  |  |  |  |  |  |  |  |  |  | Carroll Chapel   |  |  |  |  |  |  |  |  |  | Balto., MD.   |  |  |  |  |  |  |  |  |  | 8                        |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                      |  |  |  |  |  |  |  |  |  | 82                 |  |  |  |  |  |  |  |  |  | M        |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 94. FUNERAL DIRECTOR NAME   |  |  |  |  |  |  |  |  |  | 95. ADDRESS  |  |  |  |  |  |  |  |  |  | 96. DATE REC'D. BY REGISTRAR   |  |  |  |  |  |  |  |  |  | 97. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  | 98. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |  |  | 99. MONTH DAY YEAR       |  |  |  |  |  |  |  |  |  | 100. HOUR               |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Hubbard Funeral Home, Inc.  |  |  |  |  |  |  |  |  |  | 4107 Wilkens Ave. 21229  |  |  |  |  |  |  |  |  |  | AUG 16 1982  |  |  |  |  |  |  |  |  |  | John J. Cahill  |  |  |  |  |  |  |  |  |  | 8                        |  |  |  |  |  |  |  |  |  | 12                       |  |  |  |  |  |  |  |  |  | 19                      |  |  |  |  |  |  |  |  |  | 82                 |  |  |  |  |  |  |  |  |  | M        |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |





HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 4 4

REG. NO.

|  |  |  |  |   |   |   |   |  |  |
|--|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CARRIE V. YOUNG</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 7 82</b>   |   |   | 2b. HOUR<br><b>631</b> P.M.   |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>N</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 8 15</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>5 30</b>   |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MO</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2701 OAKLEY AVE.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ed Ferguson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cora A. Carpenter</b>   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Annie Crosby 2701 Oakley Ave.</b>                                |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br><b>1552</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>poor diaphragm movement 20 to 30 sec &amp; Alveoli</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ca Liver metastatic</b> |  |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>August 3</b> , 19 <b>82</b> , to <b>August 7</b> , 19 <b>82</b> that (I) (we) lost<br>saw the deceased alive on <b>August 7</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>E. Zimmerman</b>  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edward D Zimmerman</b>   |  |  | 22e. ADDRESS<br><b>Sinai Hospital</b>  |   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>8/11/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MO</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |  | ADDRESS<br><b>1101 E. North Ave</b>  |   |   | 25. DATE RECEIVED BY REGISTRAR<br><b>AUG 11 1982</b>  |   |  |  |

John J. Conner



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

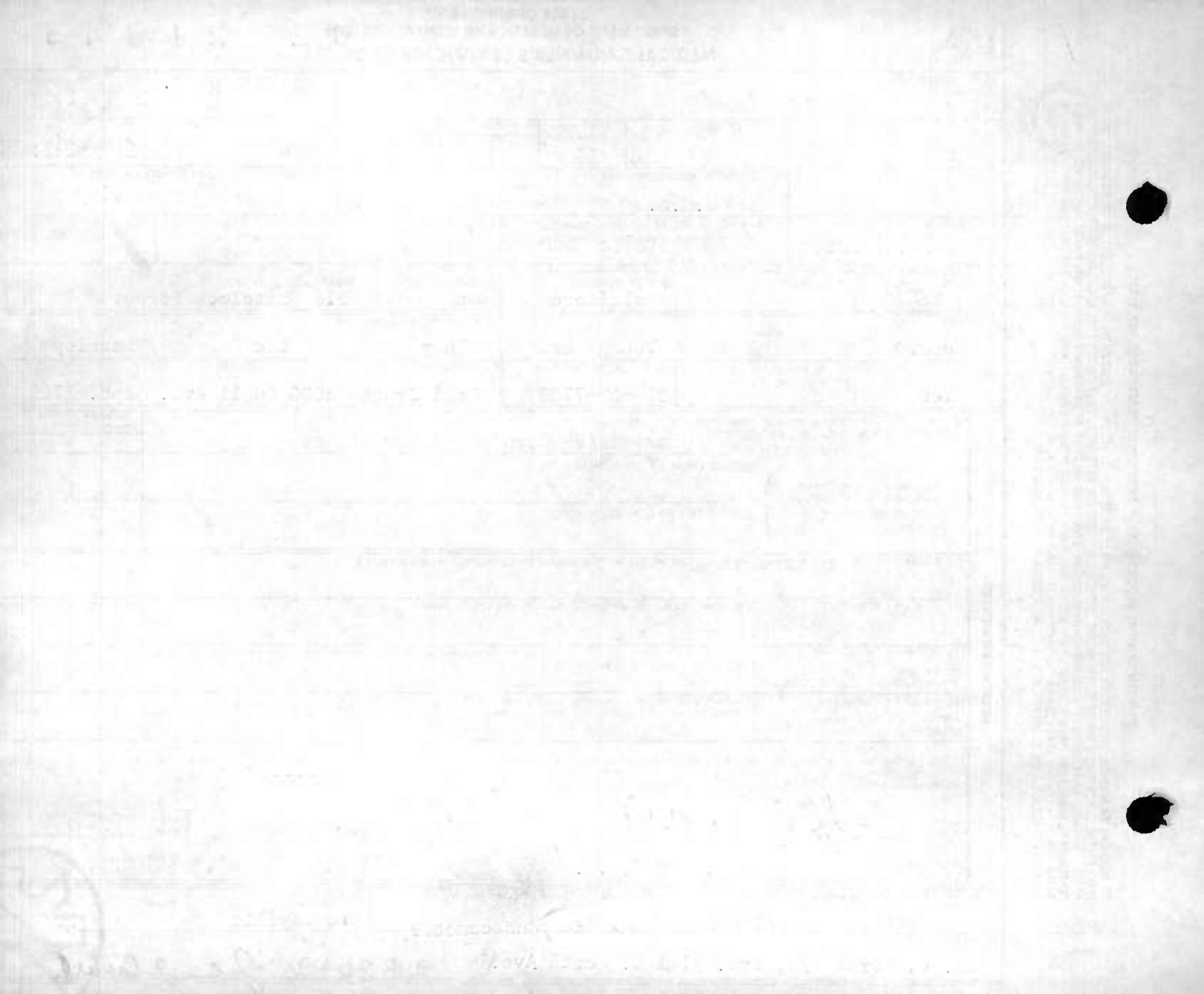
REG. NO. 21045

1- FOR  
STATE  
REGISTRAR

|  |                  |  |   |   |   |   |  |   |  |
|--|------------------|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Howard W Young  |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>8 20 19 82                |   |   | 2b. HOUR<br>M   |  |   |  |
| 3. SEX<br>male   | 4. RACE<br>black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 2 26  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>55 YRS.                     | 7. IF UNDER 1 YR.<br>MONTHS DAYS  | 8. IF UNDER 24 HRS.<br>HOURS MIN  | 2c. DATE PRONOUNCED DEAD<br>8 20 19 82  |  |   | 2d. HOUR<br>7:57 AM                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>818 Whitelock Street |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MD   |                  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>818 Whitelock Street   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Howard Young, Sr.  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruby Lee Beasley |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-20-7703   |   | 17. INFORMANT<br>ADDRESS<br>Toni Pratt 2000 Odell Ave. Apt. 1722  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                  |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |   |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br>Hormez R. Guard, M.D.  |                  |  | TITLE (SPECIFY)<br>Assistant                                      |   |   | MEDICAL EXAMINER  |  | DATE SIGNED<br>8/25/82  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.  |                  |  | ADDRESS<br>111 Penn Street, Baltimore, MD                         |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>8/25/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MD, veterans cemetery   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H, Inc.   |                  |  |   | ADDRESS<br>1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>AUG 26 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel  |  |

MEDICAL CERTIFICATION

1301



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 4 6

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
|  |  | AGNES ZAGRAIEK   |  | AUGUST 12, 1982  |  | 12:45 PM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>Jan 1, 1895  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Poland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Church Hospital |  | 12a. USUAL OCCUPATION<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md   |  | 13b. COUNTY<br>Baltimore   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br>519 S. Slater St.  |  |
| 14. FATHER'S NAME<br>John  |  | 15. MOTHER'S MAIDEN NAME<br>Friedrich                                      |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>No   |  | 17. SOCIAL SECURITY NO.<br>#  |  |
| 18. INFORMANT<br>John Zagraiek   |  | 19. ADDRESS<br>804 S. Slater St.   |  | 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARDIAC ARRHYTHMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>RESPIRATORY FAILURE</u><br>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE; STATUS POST PERMANENT<br>PNEUMONIA, LEFT LOWER LOBE; RENAL FAILURE |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| 21a. DATE OF OPERATION   |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |  | 21c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 21d. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  | 22b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                 |  | 22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)  |  | 22d. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 23a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 23b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |  | 23c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 23d. I certify that (1) this hospital attended the deceased from <u>AUGUST 7</u> to <u>82</u> to <u>AUGUST 12</u> 19 <u>82</u> that (1) (name) last<br>saw the deceased alive on <u>AUGUST 12</u> 19 <u>82</u> and that in my (name) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (name) did not view the body after death. |  |
| 24a. SIGNATURE<br>T. Kawaja  |  | 24b. DEGREE<br>M.D.  |  | 24c. DATE SIGNED<br>8/12/82  |  | 24d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T. KAWAJA, M.D.  |  |
| 25a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 25b. DATE<br>Aug 16, 1982  |  | 25c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross   |  | 25d. LOCATION<br>Baltimore Co.  |  |
| 26. FUNERAL DIRECTOR<br>NAME<br>Raymond S. Kaczmarek   |  | 26b. ADDRESS<br>2525 Clark St.   |  | 27a. DATE REC'D. BY REGISTRAR<br>AUG 17 1982   |  | 27b. REGISTRAR'S SIGNATURE<br>John J. Lohr  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be called at once.

Handwritten notes at the top of the page, including the date "1915" and some illegible text.

Handwritten notes in the middle section, including the phrase "The end of the world" and other illegible text.

Handwritten notes in the lower middle section, including the phrase "The end of the world" and other illegible text.

Handwritten notes at the bottom of the page, including the date "1915" and some illegible text.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 1 0 4 7

FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |                                    |  |   |                                   |  |                           |   |
|---|---|---|------------------------------------|--|---|-----------------------------------|--|---------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE                             | LAST   | 2a. DATE OF DEATH   | MONTH                             | DAY  | YEAR                      | 2b. HOUR  |
| MORDUKH   |   |   |                                    | ZILBERBRAND  | 8   | 8                                 | 82   | 5                         | PM  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.          |   |
| MALE  | Caucasian   | MONTH DAY YEAR<br>5 25 26   |                                    | 56   |   | YRS. MONTHS DAYS                  |  | HOURS MIN.                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |                                   |  |                           |   |
| RUSSIA  | USA   |   |                                    | BALTIMORE CITY MD.   |   |                                   |  |                           |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |                           |   |
| BALTIMORE   | SINAI HOSPITAL  |   |                                    | DRIVER   |   | TRUCKS                            |  |                           |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13b. COUNTY   | 13c. CITY OR TOWN                  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS   |                                   |  |                           |   |
| MARYLAND  |   |   | BALTIMORE                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 5901 DOVERDALE DR. #21215   |                                   |  |                           |   |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |                                    |  |   |                                   |  |                           |   |
| FIRST MIDDLE LAST<br>OSHER  |   | FIRST MIDDLE LAST<br>ZILBERBRAND  |                                    | FIRST MIDDLE LAST<br>RISL VELEDNIZKAY  |   |                                   |  |                           |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |                                    | 17. INFORMANT  |   |                                   |  |                           |   |
| NO  |   | 214-94-3497   |                                    | MRS. RAKHIA ZILBERBRAND<br>5901 DOVERDALE DR. BALTO., MD 21215                 |   |                                   |  |                           |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>2028 IMMEDIATE CAUSE (a) Myocardial hypoxia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Malignant lymphoma c anemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |                                    |  |   |                                   |  |                           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |                                    |  |   |                                   |  |                           |   |
| Asthma  |   |   |                                    |  |   |                                   |  |                           |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    |  | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                           |   |
|   |   |   |                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                           |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |                                   |  |                           |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |                                   |  |                           |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/2 19 82, to 8/8 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                |   |   |                                    |  |   |                                   |  |                           |   |
| 22b. SIGNATURE  |   | DEGREE  |                                    |  | 22c. DATE SIGNED  |                                   |  |                           |   |
| PAUL Schwartz M.D.  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                    |  | 8/8/82  |                                   |  |                           |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |                                    |  |   |                                   |  |                           |   |
| PAUL Schwartz M.D.  |   | SINAI HOSPITAL BALTO 21215  |                                    |  |   |                                   |  |                           |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION   |                                   | 23e. STATE   |                           |   |
| BURIAL  |   | AUG. 9, 1982  | CHIZUK AMUNO                       |  | BALTIMORE   |                                   | MARYLAND   |                           |   |
| 24. FUNERAL DIRECTOR  |   | 24. NAME  |                                    | 24. ADDRESS  |   | 25. DATE REC'D. BY REGISTRAR      |  | 25. REGISTRAR'S SIGNATURE |   |
| SOL LEVINSON & BROS., INC.  |   | 6010 REISTERSTOWN RD. BALTO., MD 21215  |                                    | AUG 10 1982  |   | John J. Conner                    |  |                           |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME<br>(TYPE OR PRINT)   |        |   |  | 2a. DATE OF DEATH   |     |   |  | 2b. HOUR   |     |                                   |  |  |  |
|---|--------|---|--|---|-----|---|--|--|-----|-----------------------------------|--|--|--|
| FIRST   | MIDDLE | LAST  |  | MONTH   | DAY | YEAR  |  | MONTH  | DAY | YEAR                              |  |  |  |
| Leonard Michael Zyski   |        |   |  | August 23, 1982   |     |   |  | 9:50p M  |     |                                   |  |  |  |
| 3. SEX  |        | 4. RACE   |  | 5. DATE OF BIRTH  |     |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |     |                                   |  |  |  |
| Male  |        | White   |  | MONTH DAY YEAR<br>4 9 1920  |     |   |  | 62 YRS.  |     |                                   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |        | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |     |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |     |                                   |  |  |  |
| Maryland  |        | U.S.A.  |  |   |     |   |  | Baltimore City MD.   |     |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  |     | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Baltimore   |        | Maryland General Hospital   |  |   |     | Sanitation Dept. Gen. Motors  |  |  |     |                                   |  |  |  |
| 13a. STATE  |        | 13b. COUNTY   |  | 13c. CITY OR TOWN   |     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS  |     |                                   |  |  |  |
| Maryland  |        | Baltimore   |  |   |     |   |  | 7277 Bridgewood Drive  |     |                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 17. INFORMANT   |     |   |  |  |     |                                   |  |  |  |
| Michael Zyski   |        | Maryanna Puleyski   |  | 7277 Bridgewood Drive<br>Balto., MD. 21224  |     |   |  |  |     |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)   |        | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |     |   |  |  |     |                                   |  |  |  |
| Yes   |        | WW II   |  | 213-14-4539 Bessie B. Zyski   |     |   |  |  |     |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Adenocarcinoma of Right Lung With Extensive Metastatic Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |        |   |  |   |     |   |  |  |     |                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |        |   |  |   |     |   |  |  |     |                                   |  |  |  |
| 19a. DATE OF OPERATION  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |     |                                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |     |   |  |  |     |                                   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |     |   |  |  |     |                                   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 17</u> , 19 <u>82</u> , to <u>August 23</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) lost <u>August 23</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |        |   |  |   |     |   |  |  |     |                                   |  |  |  |
| 22b. SIGNATURE<br><i>Cheryl Powell</i> MD   |        |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |     |   |  | 22c. DATE SIGNED<br><u>8/24/82</u>   |     |                                   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Cheryl Powell, M.D.  |        |   |  | 22e. ADDRESS<br>C/O Maryland General Hospital   |     |   |  |  |     |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |        | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |     |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |     |                                   |  |  |  |
| Burial  |        | 8/27/1982   |  | Gardens Of Faith  |     |   |  | Baltimore Maryland   |     |                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222  |        |   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 30 1982  |     |   |  | 25b. SIGNATURE<br><i>John J. Smith</i>   |     |                                   |  |  |  |

August 23, 1982 9:50

Baltimore City

Maryland General Hospital

Baltimore

Respiratory Failure

Adenocarcinoma of Right Lung with Extensive  
Metastatic Disease

August 23 1982 X  
August 17 1982 X  
August 23 1982 X

C/O Maryland General Hospital

Cheryl Smith, M.D.

August 23, 1982